Universidade do Minho
Escola de Psicologia

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Programa Doutoral em Psicologia
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Trabalho efetuado sob a orientação do
Professor Doutor Miguel M. Gonçalves
e co-orientação da
Professora Doutora Eugénia Ribeiro

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DECLARAÇÃO

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"People are just as wonderful as sunsets if you let them be. When I look at a sunset, I don't find myself saying, "Soften the orange a bit on the right hand corner." I don't try to control a sunset. I watch with awe as it unfolds"

Carl Rogers

First of all, I would like to thank all the persons who told me their stories in therapy, showing me that, as molecules and small particles in the atmosphere may change the direction of light rays and create different colorful sunsets, so their unique experiences and meanings provided a singular richness to our shared stories, triggering all my curiosity and admiration as a therapist but even more as a person. It was through each session with them that I discovered how I feel honored to spend so many minutes of my life doing and studying the art of psychotherapy.

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NARRATIVE CHANGE IN CONSTRUCTIVIST GRIEF THERAPY: THE INNOVATIVE MOMENTS MODEL

ABSTRACT

This dissertation explores the process of narrative change in constructivist grief therapy through the lens of the Innovative Moments Model. According to this model – grounded in the narrative perspective of human change – clients reformulate the problematic narratives brought to therapy by investing in the elaboration of *Innovative Moments* (IMs), pictured as alternative experiences in their lives that fall outside the domain of the problematic self-narrative. Associated with this investment in self-narrative transformation throughout therapy, this dissertation also explores how problematic self-narratives can be maintained by the elaboration of *return to the problem markers* (RPMs), instigating a movement of ambivalence between the new self-narrative (IMs) and the old one (RPMs). In order to understand how complicated grief clients invested in the maintenance or transformation of their problematic self-narratives (or problematic stories of loss) throughout therapy and which narrative processes could be associated with change and ambivalence, a set of studies were conducted and presented in this dissertation. The first study presented an intensive analysis of a good outcome case of constructivist grief therapy with a bereaved mother, using the "Innovative Moments Coding System" (IMCS). Results showed that the emergence and expansion of IMs were associated with a gradual transformation of the problematic self-narrative into a more healthful story of loss, demonstrating the feasibility of analyzing narrative change with the IMCS in this form of therapy. The second study investigated the processes of change (through IMs) and ambivalence (through RPMs) in two cases of constructivist grief psychotherapy. The research strategy involved three steps: 1) tracking IMs with the IMCS, 2) exploring the themes expressed therein (or *protonarratives)* through grounded theory analysis and 3) analyzing the emergence of RPMs with the "Return to the Problem Coding System" (RPCS), which is an empirical system that tracks every time an IM is attenuated by a RPM. Results showed that both cases presented a high percentage of RPMs, and that the evolution of IMs and RPMs over sessions was significantly correlated, being mainly organized around the themes "Integration" (new integration of loss centered on the construction of a new symbolic relationship with the deceased) and "Proactivity" (search for moments of well-being). Considering these

results, we hypothesized that the stability of ambivalence in grief therapy may represent a form of self-protection from the anxiety of changing (and releasing the intense pain towards a more adaptive experience of loss) as a disconnection from the deceased. The third study aimed to further understand how IMs depicted the movement of self-narrative transformation in constructivist grief therapy. The emergence of IMs was analyzed using the IMCS among a sample of six cases of constructivist grief therapy. The association between IMs development and the severity of grief symptomatology was also analyzed. Grief symptomatology was assessed using the "Inventory of Complicated Grief" (ICG). A thematic analysis was performed to explore the evolution of IMs through elaboration of the themes "Integration" and "Proactivity", identified as relevant processes in loss adaptation in the previous study. A generalized linear model analysis (GLM) showed a different rate of IMs production over time between cases with different clinical outcomes. More specifically, cases with greater improvement changed the probability of having IMs with a higher rate over time than cases with less improvement. Results also showed that the themes "Integration" and "Proactivity" had a high prevalence in this sample, highlighting the relevance of these narrative processes in grief therapy. In general, we conclude that the results of this study reinforce IMs' relevance in studying narrative change among cases with distinct clinical progressions. The fourth and last study aimed to further analyze the process of ambivalence in constructivist grief therapy. The six cases previously analyzed with the IMCS in the third study were now analyzed with the RPCS. The association between RPMs and the severity of grief symptomatology was also examined, considering the ICG scores. The results showed that RPMs emerged in all cases. The application of a GLM analysis showed that the probability of these RPMs decreased over time in cases with greater symptomatic improvement, while the opposite occurred in cases with less improvement. These results suggest an association between symptom improvement and the reduction of ambivalence, supporting previously reported findings.

MUDANÇA NARRATIVA NA TERAPIA CONSTRUTIVISTA DO LUTO: O MODELO DOS MOMENTOS DE INOVAÇÃO

RESUMO

A presente dissertação centra-se no fenómeno da mudança narrativa na psicoterapia construtivista do luto, estudado à luz do modelo dos "Momentos de Inovação". Este modelo, de base narrativa, propõe que a mudança em psicoterapia ocorre a partir da elaboração e expansão de "Momentos de Inovação" (MIs), descritos como experiências que não se enquadram no domínio da auto-narrativa problemática. A par do estudo da emergência de MIs, esta dissertação explora também a forma como a auto-narrativa problemática pode ser reativada e mantida ao longo do processo psicoterapêutico, sempre que a emergência de um MI é atenuada pela emergência de marcadores de retorno ao problema (MRPs). Esta reativação da auto-narrativa problemática e consequente atenuação de MIs representa um fenómeno de ambivalência em psicoterapia, no qual se cria um ciclo repetitivo entre a auto-narrativa problemática e a auto-narrativa alternativa. Procurando perceber o impacto que a elaboração de MIs e MRPs tem na manutenção ou transformação das auto-narrativas problemáticas ao longo da terapia do luto, foram realizados diferentes estudos que serão apresentados ao longo desta dissertação. O primeiro estudo apresenta uma análise intensiva de um caso de sucesso terapêutico seguido em terapia construtivista do luto, estudado através do "Sistema de Codificação dos Momentos de Inovação" (SCMI). Em geral, os resultados deste estudo indicam uma associação entre o desenvolvimento e expansão dos MIs e a transformação gradual da auto-narrativa problemática numa auto-narrativa mais saudável e flexível, o que atesta a viabilidade e adequabilidade do SCMI no estudo da mudança narrativa neste tipo de terapia. No segundo estudo investigaram-se os processos de mudança (MIs) e ambivalência (MRPs) em dois casos de terapia construtivista do luto. A estratégia de investigação utilizada envolveu três passos: 1) a identificação de MIs através do SCMI, 2) a identificação dos temas por estes expressos (protonarrativas) através da *grounded analysis* e 3) a análise da emergência de MRPs após a elaboração de MIs, através do "Sistema de Codificação do Retorno ao Problema" (SCRP). Os resultados deste estudo demonstram uma alta percentagem de MRPs em ambos os casos. Verificou-se também uma relação significativa entre MIs e RPMs ao longo das sessões de ambos os processos psicoterapêuticos, maioritariamente

organizados em torno dos temas "Integração" (nova integração da perda associada à construção de uma nova relação com a pessoa perdida) e "Proatividade" (procura de momentos de bem-estar). Face a estes resultados, sugere-se que os clientes em luto possam ativar e manter uma resposta de ambivalência à mudança como forma de se protegerem da ansiedade produzida pelo facto de perceberem a sua mudança como um "abandono" da pessoa perdida. O terceiro estudo pretende aprofundar a análise da emergência de MIs na terapia construtivista do luto. Neste sentido, utilizou-se o SCMI numa amostra de seis casos de luto complicado seguidos em terapia construtivista, procurando explorar a associação entre o desenvolvimento de MIs e a severidade da sintomatologia de luto complicado, a qual foi avaliada através do "Inventário de Luto Complicado" (ILC). Também foi levada a cabo uma "análise temática" no sentido de explorar a emergência de MIs ao longo dos temas "Integração" e "Proatividade", identificados no estudo anterior como temas relevantes na adaptação à perda. Os resultados do estudo demonstram uma progressão de produção de MIs ao longo do tempo significativamente diferente entre casos com diferentes resultados clínicos. Mais especificamente, os casos com maior mudança clínica revelaram uma progressão de produção de MIs ao longo do tempo significativamente maior do que os casos com menor mudança clínica. Este estudo também mostrou uma elevada prevalência dos temas "Integração" e "Proatividade" nesta amostra, corroborando a relevância destes temas na terapia do luto, como sugerido anteriormente. Em geral, conclui-se que estes resultados reforçam a adequabilidade do modelo dos MIs no estudo da mudança narrativa em casos com diferentes evoluções clínicas. O quarto e último estudo pretende aprofundar a análise do fenómeno de ambivalência na terapia construtivista do luto. Para isso, os seis casos codificados com o SCMI no estudo anterior foram agora codificados com o SCRP, onde se analisou a emergência de MRPs após a elaboração de MIs. A associação entre a emergência de MRPs e a evolução clínica de cada caso da amostra foi igualmente explorada, considerando os resultados obtidos no ILC. Os resultados indicam que a emergência de MRPs é transversal a todos os casos. Uma análise de regressão mostrou ainda que a probabilidade da ocorrência desses MRPs foi decrescendo ao longo do tempo nos casos com maior mudança clínica, enquanto o contrário se verificou nos casos com menor mudança. Face aos resultados obtidos, concluiu-se que existe uma associação entre a amplitude da mudança clínica e a resolução da ambivalência, corroborando os resultados obtidos noutros estudos.

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INTRODUCTION

> "There is not one big cosmic meaning for all, there is only the meaning we each give to our life...like an individual novel, a book for each person"
>
> Anaïs Nin

The purpose of understanding how psychotherapy contributes to clients' change has motivated several clinicians and researchers over the history of psychotherapy research. The discursive and interpretive perspectives that emerged at the end of the last century – proposing an alternative analysis of human change decentered from the more positivist and rationalist perspectives – opened space to a wider attention on the way human beings create personal realities to systematically organize their experiences (Bruner, 1986; Neimeyer, 2009a; Neimeyer & Raskin, 2000; Raskin, 2002). The development of this interpretative epistemology at the level of psychology and psychotherapy highlighted the aspects of language, social negotiation and human meaning making (Bruner, 1990; Freedman & Combs, 1996; Gergen, 2001; Gonçalves, 2003; Neimeyer, 2009a; Shotter, 1992), emphasizing clients' *agentive* role in their own change process (White & Epston, 1990). The concept of "narrative" emerged at this point as a privileged metaphor for the understanding of human experience (Bruner, 1986; McAdams, 1993; Polkinghorne, 1988; Sarbin, 1986), assuming a central role in psychotherapeutic change (Angus & McLeod, 2004; Gonçalves & Ribeiro, 2012; White & Epston, 1990). The work presented in this dissertation relies on this narrative constructivist perspective of change, which will be further explored in this introduction section. In the *Innovative Moments* research group at University of Minho – where I developed my work – I was taught to bring clients' descriptions to the center of the research *arena*, privileging their unique way of reinventing their lives.

This dissertation presents four studies centered on the phenomenon of narrative change in constructivist grief therapy (Neimeyer, 2001; 2006a) developed from September 2008 to December 2012. In order to contextualize this research work and

its evolution, I use this introduction to globally frame the research conducted on innovative moments particularly in the context of grief therapy.

This introduction is divided in five sections. The first section describes the main assumptions proposed by the constructivist grief therapy (CGT) model, given that this is the intervention in focus in the studies presented in this thesis. A further description of the phenomenon of complicated grief is also addressed, considering the diagnosis criteria proposed by Prigerson and collaborators (1995, 2009). The second section, entitled "Narrative Change in Psychotherapy", addresses the narrative background that oriented our research work, further elaborating on the concepts of *self-narrative*, *problematic/dominant self-narrative* and introducing the concept of *innovative moments*. The third section describes the *Innovative Moments Model*, its main assumptions, methods and findings, considering that it is the central methodology used in this thesis to study narrative change in CGT. More specifically, it is explored how this methodology allows the study of two different processes: a) the problematic self-narrative transformation associated with the emergence and expansion of Innovative Moments (IMs) and b) the problematic self-narrative maintenance associated with IMs' attenuation by a return to the problematic self-narrative. Finally, the fourth and last section presents the several research questions that oriented the four studies, providing background for the succeeding chapters.

1 CONSTRUCTIVIST GRIEF THERAPY: THE MEANING RECONSTRUCTION APPROACH

"When we have let go of enough
of what we were
and grow perfect in our nothingness,
we will at last find an end
to the yearning,
and finally
have room for you"

Robert A. Neimeyer, 2009b, p. 21, *in* The Art of Longing.

Viewed upon the narrative-constructivist perspective in which this thesis develops, human beings are seen as active participants in the construction of their own realities, organizing the multiplicity of life experiences in personal stories or

self-narratives, shared and co-constructed with others (Bruner, 2004; Freedman & Combs, 1996; McAdams, 1993; Polkinghorne, 2004; Sarbin, 1986; White & Epston, 1990). It is precisely this meaningful structure or self-narrative that can be shattered by unexpected or incongruous life events such as the death of a significant person (Calhoun & Tedeschi, 2006; Neimeyer, 2006a). In the words of Robert Neimeyer, "like a novel that loses a central character in the middle chapters, the life story disrupted by loss must be reorganized and rewritten, to find a new strand of continuity that bridges the past with the future in an intelligible fashion" (2001, p. 263).

Each person engages in this voyage of *finding* and *making* meaning in the aftermath of death in a unique way (Neimeyer, 2000). And it is specifically this unique way of integrate loss and reconstruct life after death that is addressed in this thesis, contextualized to the specific set of therapy. My goal is to frame the experience of grief in the spirit of the narrative-constructivist tradition of psychology that is my home base. Therefore, I will start this section by describing the theoretical and conceptual evolution of grief theory until the emergence of the meaning reconstruction approach (Neimeyer, 2001, 2006a; Neimeyer & Sands, 2011) and how this perspective constitutes an alternative to the traditional theories of grief and bereavement. Then, I will describe the main therapeutic assumptions proposed by the meaning reconstruction approach and give examples of constructivist-narrative techniques that were relevant in the therapeutic processes with the cases analyzed in this dissertation. Finally, I will describe the classification of "complicated grief" used in this thesis, according to the diagnosis criteria proposed by Prigerson and collaborators (1995, 2009).

1.1 Grief theory: from the standard models to the meaning reconstruction approach

For most of the 20th century, grief was described as an intrapsychic process associated with the relinquishment of emotional bonds with the deceased and the reestablishment of the previous "normal" functioning (Freud, 1957; Lindemann, 1944). Anchored in psychodynamic and cognitive behavioral formulations, the

standard paradigms suggested a model of grief focused on a series of psychological transitions towards grief recovery (Bowlby, 1980; Worden, 1983). This focus on universal stages of grief inspired many academics and clinicians, oriented towards a stress-oriented perspective that posits the person in the midst of a pre-determined trajectory from shock and denial to anger and depression before landing in loss acceptance (Kubler-Ross, 1969). The person's inability to address these tasks would result in maladjustment and "unresolved" grief.

Despite their popularity, these stage-based models lack empirical validation, since the majority of studies didn't find any noticeable sequence of emotional stages associated with recovery (Holland & Neimeyer 2010; Stroebe, 1992; Wortman & Silver, 1989). In consequence of this lack of validation and instigated by a constructivist and interpretative shift in psychology (Neimeyer & Mahoney, 1995; Neimeyer & Raskin, 2000), a new wave of grief theories start to emerge, proposing a different perspective about the role of loss in human experience. Being skeptic about the universal trajectory to grief adjustment, these contemporary perspectives emphasize the human potential to create different, personal or even unexpected responses to loss (Attig, 1996), not necessarily anchored in stress and suffering (Neimeyer, 2001). Likewise, they start to question the assumption that successful grieving requires a disconnection from the deceased (Klass, Silverman, & Nickman, 1996). Despite the irreversibility of the physical separation, the relevance of maintaining more representational or symbolic bonds with the lost loved one is now recognized (Attig, 2001; Field & Friedrichs, 2004; Klass, Silverman, & Nickman, 1996). More than just letting go of the past and investing in a different future without the lost person, it is important to allow the construction of a new relationship that suits the changed reality (Neimeyer, 2001).

1.1.1 The Meaning Reconstruction Approach

The *meaning reconstruction approach* (Neimeyer, 2000, 2001, 2006a) emerged among these new perspectives, emphasizing meaning reconstruction as the central process in grieving. Formulated under a constructivist background, this approach suggests that the understanding of grief and loss should consider the distinctive ways in which different persons interpret the experience of loss and reconstruct a personal

reality in the aftermath of it (Neimeyer, 2001). Therefore, it views grievers as active agents attempting to renegotiate their self-narratives in the wake of loss, creating a new coherent interplay between the self and the broader social and interpersonal contexts (Attig, 1996; Neimeyer, 2001).

From the constructivist perspective, loss does not necessarily disorganize survivors' self-narratives, as many of them keep finding support in previous meaning systems and personal practices that still provide them a meaningful structure to integrate loss (Attig, 2000). From this standpoint, individuals who present a "normative grief reaction" (Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010, p. 75) are successful at engaging in meaning reconstruction and integrating loss in their previous meaning systems, maintaining a coherent and consistent story in the aftermath of death (Coleman & Neimeyer, 2010; Keesee, Currier, & Neimeyer, 2008; Murphy, Johnson, & Lohan, 2003; Neimeyer et al., 2010).

Some persons, in contrast, may find particularly difficult to reach self-continuity after a major loss, as this experience may contradict important assumptions that sustained their previous lives (Kauffman, 2002; Neimeyer, 2006a); their existence may no longer be punctuated by a sense of predictability and coherence, feeling betrayed by a world that doesn't guarantee their safety and happiness anymore (Janoff-Bulman 1992; Park & Folkman, 1997). As suggested by Neimeyer (2002, 2005), when the person is not capable of reformulating a world of significance in order to integrate loss, he or she may be forced to deal with an oppressive or hopeless story that colonizes his or her life and cannot be acknowledged in its essential details. This narrative disruption is commonly associated with complicated and prolonged grief reactions (Neimeyer, 2005; Prigerson et al., 2009). To provide a clearer understanding about the particularities of complicated grief (Prigerson et al., 1995, 2009), a psychopathological definition of this category will be provided in section 1.3.

Recent research on complicated grief supports the broad outline of Neimeyer's meaning reconstruction model, showing that the inability to find meaning in the experience of loss is a central marker of incapacitating grief distress among many populations (Prigerson et al., 2009). In a large pool of adults suffering a variety of losses, for example, inability to give meaning and integrate the experience of loss was associated with severe separation distress during the first two years of adaptation (Holland, Currier, & Neimeyer, 2006).

1.2 Grief Therapy as meaning reconstruction

According to Neimeyer and collaborators (2010), individuals with complicated grief reactions may benefit from psychotherapeutic interventions that foster meaning reconstruction and help them invest in a new self-narrative that suits their changed reality. Indeed, several therapeutic procedures formulated in order to foster meaning reconstruction start to receive empirical support in randomized controlled trials (Lichtenthal & Cruess, 2010; Shear, Frank, Houck & Reynolds, 2005; Wagner, Knaevelsrud & Maercker, 2006).

From the standpoint of the meaning reconstruction approach (Neimeyer, 2001, 2012a; Neimeyer & Sands, 2011), grief therapy shall be oriented toward an empathic responsiveness to the needs and expectations of each grieving client. Thus, it is important that the therapist foments a safe and supportive context in which the client may reopen his or her story of loss and share important details of it. As pointed out by Neimeyer, it is also important that the therapist "does not decide what meanings will be reconstructed and which will be reaffirmed in the wake of loss but instead assists clients in recognizing incompatible old meanings or constructs and works with them as they endeavor to find alternatives" (2012a, p.4). In line with Neimeyer's assumptions, I consider that each therapeutic process is a unique adventure that can be much more interesting if we – therapists – encourage clients to invent their own language of change (resulting from their imagination and creativity), collaborating actively with us in the exploration of which experiences and meanings are now incompatible with their priorities and plans.

After the creation of a secure relationship in which the client may feel confortable to share more private meanings, it is also important that each therapeutic process respects clients' timing of change (Neimeyer, 2012a). That is, it is important to consider each client readiness to change and propose specific therapeutic activities in accordance to it.

Several techniques may be considered to foster meaning reconstruction in therapy. Narrative interventions, for instance, gain special relevance as important techniques in promoting alternative perspectives to the event of death (Neimeyer, 1999; Neimeyer et al., 2010). These include evidence-based practices of "narrative retelling" (Neimeyer et al., 2010, p.76) that stimulate the client to revive the story of the loss until the hardest details and meanings can be held in a less distressing way

(Shear et al., 2005); or writing about the possible unexpected "beneficial facet" of this experience (Lichtenthal & Cruess 2010).

Examples of constructivist-narrative techniques that were relevant in the therapeutic processes with the clients that integrate the sample studied in this dissertation are presented next.

1.2.1 Constructivist-narrative techniques

- *Meaning Reconstruction Interview*

The "Meaning Reconstruction Interview" (Neimeyer, 2006a, pp.166-169) oriented the initial sessions with the clients included in this sample. This interview offers a broad range of "entry", "explanation" and "elaboration" questions that help the therapist inaugurating the therapeutic process under a meaning-oriented structure (Neimeyer, 2006a). I will give examples of some of these questions.

The "entry questions" are formulated in order to help the therapist "move into the experiential world of the client" (Neimeyer, 2006a, p.166) and engage in an empathic listening and curiosity about the details of his or her story:

> *What do you recall about how you responded to the event at the time?*
>
> *What was the most painful part of the experience to you?*
>
> *Who were you at the time of the loss, at the level of your basic personality, stage of development, and central concerns?*

The "explanation questions" expand this preliminary approach to client's meanings, exploring how he or she has been organizing this experience over time and which features of his or her "assumptive world" (Parkes, 1988) has been changing over time due to this process.

> *How did you make sense of the death or loss at the time? And now?*
>
> *What philosophical or spiritual beliefs contributed to your adjustment to this loss? How were they affected by it, in turn?*
>
> *Are there ways in which this loss disrupted the continuity of your life story?*

Finally, the "elaboration questions" promote a broader perspective on the transformation process in which the person has been engaged since the death of the loved one. It also promotes the exploration of the expectations regarding the change process, as the person can hear him or herself (sometimes for the first time) about what he or she wants for his or her future (priorities) and which paths could be considered to achieve this transformation.

> *How has this experience affected your sense of priorities?*
>
> *How has this experience affected your view of yourself or your world?*
>
> *Are there any steps that you could take that would be helpful or healing now?*

As suggested by Neimeyer (2006a), some persons may find the process of thinking on the responses to these questions to be therapeutically powerful in itself, addressing some aspects of their experiences in an innovative way. The therapist may also suggest that the client continues elaborating on some of these questions outside therapy, and then sharing the results in the following session. That is, more than using this interview in a rigid structure, the therapist selects which questions are more appropriate to explore with a specific client and assign them in a flexible way.

- *Therapeutic Writing: unsent letters*

A relevant therapeutic writing activity is the letter writing or "unsent letters" (Neimeyer, 2006a, p.196; Neimeyer, 2012b), pictured as an attempt to reopen the dialogue with the deceased and address some questions, reflections, fears and thoughts that emerged in the aftermath of death or other aspects that the person could not ask or say to the lost one due to his or her physical disappearance.

These letters are not formulated under a "goodbye" perspective but as a "hello again" initiative (Neimeyer, 2012b; White, 1989). The use of this technique is consistent with the contemporary models of grief described above, and has been addressed as one of the techniques incorporated in empirically supported interventions for complicated grief (Wagner, Knaevelsrud, & Maercker, 2006).

Neimeyer (2012b, p. 259) suggests some guidelines that can be helpful in initiating this type of written conversation, such as:

What I have always wanted to tell you is…

What you never understood was…

The one question I have wanted to ask is…

I want to keep you in my life by…

The combination of this technique with "empty chair" or imagery-based dialogue with the deceased (Shear, Boelen, & Neimeyer, 2011) also constitutes a powerful activity especially for those who may be stuck in painful meanings or memories (Neimeyer, 2012b).

1.3 Complicated Grief or Prolonged Grief Disorder: diagnosis criteria

Although the majority of individuals react adaptively to loss (Bonanno, 2004), research has been demonstrating that 10% to 20% show complicated grief (CG; Prigerson et al., 1995; Prigerson & Jacobs, 2001) or Prolonged Grief Disorder[1] (PGD; Boelen & Prigerson, 2007; Prigerson et al., 2009), characterized by intense and persistent mental distress. This category stands out as a psychopathological condition with specific diagnostic criteria, as proposed by Prigerson et al., (2009):

A. Event criterion: Bereavement (loss of a loved person).

B. Chronic and persistent separation distress: the person experiences yearning (e.g., craving, pining, or longing for the deceased; physical or emotional suffering as a result of the desired, but unfulfilled, reunion with the deceased) daily or to a disabling degree.

C. Cognitive, emotional, and behavioral symptoms: the person must have five (or more) of the following symptoms experienced daily or to an incapacitating degree:

1. Confusion about one's role in life or diminished sense of self (i.e., feeling that a part of oneself has died)

[1] The term ''prolonged grief disorder'' has been proposed most recently to describe this prolonged and incapacitating reaction to

2. Difficulty accepting the loss
3. Avoidance of reminders of the reality of the loss
4. Inability to trust others since the loss
5. Bitterness or anger related to the loss
6. Difficulty moving on with life (e.g. making new friends, pursuing interests)
7. Numbness (absence of emotion) since the loss
8. Feeling that life is unfulfilling, empty, and meaningless since the loss
9. Feeling stunned, dazed, or shocked by the loss

D. Duration: Diagnosis should not be made until at least six months have elapsed since the death.

E. Impairment: The above symptomatic disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (e.g. domestic responsibilities).

F. Relation to other mental disorders: Not better accounted for by Major Depressive Disorder, Generalized Anxiety Disorder, or Posttraumatic Stress Disorder.

Research indicates that complicated grief symptoms significantly increase the risk of suicide behavior (Latham & Prigerson, 2004), cancer, heart disease, and sleep disturbances (Prigerson, Bierhals, et al., 1997). Thus, several mental health professionals and researchers have been suggesting its inclusion in the *Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition* (*DSM-5*), fostering the development of new assessment methods and intervention protocols (Shear et al., 2011).

Typically, prolonged and incapacitating grief is classified as Major Depression Disorder (Prigerson et al., 1999) or Post-Traumatic Stress Disorder (PTSD), due to symptoms overlap with these disorders (Shear, Jackson, Essock, Donahue, & Felton, 2006). However, recent research shows that complicated grief can be differentiated from the other 2 categories (Boelen & Van den Bout, 2005; Boelen, Van den Hout, & Van den Bout, 2008). For instance, while complicated grief has the loss of a loved one as the event that caused the mental distress, MDD proposes this event as an exclusion criterion. Moreover, while yearning symptoms are the central group of symptoms in complicated grief, depressed mood or anhedonia are the main ones in

MDD and intrusive symptoms are the main ones in PTSD. Thus, the new diagnosis for complicated grief would be relevant in describing and clarifying these central features associated with a severe and protracted grief experience (Neimeyer, 2008; Prigerson et al., 1997).

2 NARRATIVE CHANGE IN PSYCHOTHERAPY

According to the narrative metaphor, human stories or self-narratives "not only govern which meanings are attributed to events, but also select which events are included and which are left out of the story'' (Polkinghorne, 2004, p. 58). That is, organizing and interpreting experience through narrative involves a dynamic and selective process (Adler, Skalina & McAdams, 2008; McAdams, 1993) through which the narrated events – micro-narratives – "come to be articulated, experienced, and linked together" (Angus, Levitt, & Hardtke, 1999, p. 1255). With the adoption of this narrative background to psychotherapy research, several research programs began to pay close attention to the impact of exploring personal self-narratives and promote their re-elaboration in therapy (Angus et al., 1999; Crits-Christoph, Connolly, & Shaffer, 1999; Pennebaker & Segal, 1999; Stiles, Honos-Webb, & Lani, 1999), emphasizing clients' investment in self-narrative transformation through meaning reconstruction as a central mechanism for therapeutic change.

2.1 Problematic self-narratives and Innovative Moments

As a result of the selective process around which only part of the lived experience is provided with meaning and integrated in a structured self-narrative (McAdams, 1993; White & Epston, 1990), individuals may be situated in stories that do not sufficiently incorporate the richness and diversity of their lives (White & Epston, 1990). On this stance, when clients seek therapy, they are typically under the influence of problem-saturated stories (White, 2007; White & Epston, 1990) that confine their life to a single scenario and inhibit the emergence of new experiences, new relationships and new possibilities for meaning creation (Freedman & Combs, 1996; Neimeyer, 2005; White, 1995). As pointed out by White & Epston (1990), these stories are usually "unhelpful, unsatisfying, and dead-ended" (White & Epston, 1990, p.14).

Neimeyer, Herrero and Botella (2006) suggest that these problem-saturated stories represent a form of "narrative dominance" (p.132), which confines an individual's self-narrative into a single description, silencing important meanings and perspectives that are not consistent with the general rule or theme. In this sense, the same dominant theme keeps repeating itself, dismissing discrepant experiences that contradict it and narrowing peoples' understanding about themselves and their world (Dimaggio, 2006; Hermans & Kempen, 1993; White & Epston, 1990). For example, in a grieving experience, narrative dominance may occur when the person's life becomes regulated by the problematic "narrative of loss". That is, when his or her self-narrative becomes biased towards the most painful and threatening descriptions of his or her reality after loss (Currier & Neimeyer, 2006), interpreting the diversity of life events according to this dominant narrative account.

Evidently, not all forms of narrative dominance are problematic. In the majority of times, persons organize their meanings around flexible dominant narratives that bring consistency and predictability to their lives (Neimeyer, 2009a). The problematic dominant self-narratives or *same-old stories* (Angus & Greenberg, 2011), in contrast, restrain flexibility by inhibiting other narrative possibilities to emerge, bringing a problematic redundancy to persons' lives (Neimeyer et al., 2006; White & Epston, 1990). From now on we use the term "problematic self-narrative" to denote this maladaptive facet of persons' dominant stories, typically associated with implicit rules of meaning that constrain the way they experience the world (White, 2007; White & Epston, 1990).

According to White and Epston (1990), problematic self-narratives can be challenged by the emergence and amplification of aspects of the experience that tend to be ignored by the dominant narrative. In this perspective, therapy can be an opportunity for achieving a new sense of personal coherence and structure by bringing the client's awareness to these exceptional moments or *unique outcomes* opposing the problem (White, 2007; White & Epston, 1990). These *unique outcomes* (White & Epston, 1990) constitute a potential "entryway for inviting people to tell and live new stories" (Combs & Freedman, 2004, p. 144) and emerge every time clients act, feel or think in new ways that contradict the problematic self-narrative's rules.

Gonçalves and collaborators (e.g. Gonçalves, Matos & Santos, 2009) prefer referring to these unique outcomes (White & Epston, 1990) as *innovative moments*

(IMs), highlighting their recurrent emergence throughout the therapeutic process (opposed to the term "*unique",* that might suggest that these experiences tend to be rare). Also, the term *outcomes* stresses results, and these innovations are more associated to a developmental process, building up gradually as the process of self-transformation progresses. The term "innovative moments" will be used for the remainder of this thesis to reflect clients' investment in self-transformation throughout therapy.

3 THE INNOVATIVE MOMENTS MODEL

In the perspective of the Innovative Moments Model (Gonçalves, Matos et al., 2009), change in psychotherapy occurs as clients progressively move from the maintenance of problematic self-narratives to its transformation through the development and expansion of innovative moments (IMs). In this sense, while the problematic self-narrative is the maladaptive rule (constraining certain types of behaviors, feelings, thoughts), IMs are the exceptions to this rule (e.g. new actions, new feelings, new thoughts). This model suggests that some repetition of the new meanings (IMs) is needed to surpass the former problematic self-narrative and instigate a more inclusive meaning-making process (Gonçalves, Matos et al., 2009). It also suggests that this process of meaning transformation is linked with the emergence and interaction of different types of IMs, suggesting IMs' diversity as another relevant aspect of the change process (Gonçalves, Matos et al., 2009; Ribeiro, Mendes et al., 2012).

3.1 Innovative Moments Coding System

The Innovative Moments Coding System (IMCS; Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011) is a qualitative method that allows researchers to identify different IMs in contrast to the previous problematic self-narrative that brought the client to therapy. For example, if the incapacity to reconstruct life in the aftermath of death in a less severe painful way is the main theme that characterizes the problematic self-narrative of a complicated grief client that seeks therapy (e.g. "I lost everything, I only have this intense pain that takes all my energy and transforms my life into this agony"), an IM would occur each time the person invests in alternative experiences (to this severe pain) that

contribute to life reconstruction, emerging in the form of thoughts, actions or feelings (e.g. “I don't want to live like this anymore, I want to find some peace and some comfort in something, I feel that I deserve it and I know that the person I lost would be proud of me by trying it”).

This coding system considers both client’s and therapist’s conversations as relevant contributions to the emergence of novelties, based on the assumption that change is co-constructed in the therapeutic interaction (Angus et al., 1999). In this sense, IMs can be elicited directly by the client without any therapist’s intervention but they can also emerge as a consequence of questions or statements of the therapist, as long as the client accepts it.

Five different categories of IMs are proposed: action, reflection, protest, reconceptualization and performing change. Action IMs refer to new actions or new specific behaviors that counter the problematic self-narrative and have the potential to create new meanings. Reflection IMs involve new thoughts, understandings, feelings or other cognitive products that challenge the dominance of the problematic self-narrative in the client’s life. Protest IMs, in turn, involve new behaviors (like action IMs) and/or new thoughts (like reflection IMs) that defy the problematic pattern, representing a refusal of its assumptions. This active refusal is the central feature that distinguishes protest from action and reflection. Reconceptualization IMs are a more complex type of IM that enable the clients’ comprehension about what is different about themselves and the process that fostered this transformation. This specific IM requires the clients’ description of three components: the self in the past (problematic self-narrative), the self in the present and the process that allowed for this change to take place. Finally, performing change IMs refer to projects, activities or experiences – anticipated or already acted – that become possible due to the changes developed so far. Further description of each IM type (with examples) and the IMCS’ coding process and reliability will be provided in all the chapters of this thesis.

Thus far, several samples and therapeutic models have been studied with the IMCS, such as victims of intimate violence followed in narrative therapy (Matos, Santos, Gonçalves, & Martins, 2009) and clients diagnosed with major depression followed in emotion-focused therapy (Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Mendes et al., 2010) and client-centered therapy (Gonçalves, Mendes, Cruz et al., 2012). Overall, these studies have presented consistent findings regarding the emergence and pattern of IMs in good and poor outcome cases. First of

all, they showed that IMs emerged in all cases, most of the times from the first session until the end, regardless of the therapeutic outcome. Thus, even when the problematic self-narrative keeps dominating the person's story, there are always novelties appearing and new opportunities for self-transformation occurring, even if they are ignored or trivialized. However, a main distinctive feature was that the emergence and diversity of IMs was significantly higher in good outcome cases (GO) when compared to poor outcome cases (PO). In GO cases, action, reflection and protest IMs emerged at the beginning of therapy, progressing to reconceptualization and performing change in the later phases of therapy. In PO cases, in turn, action, reflection and protest were the main IMs of the entire process, not progressing to reconceptualization and performing change as typically occurred in successful change. The consistency of these findings lead Gonçalves and colleagues (Gonçalves, Matos & Santos, 2009) to elaborate a heuristic model of narrative change that will be described in the next lines.

3.2 Heuristic Model of Change

From the several studies using the IMCS in different therapeutic modalities mentioned above, Gonçalves and collaborators (e.g. Gonçalves, Matos & Santos, 2009; Matos et al., 2009) developed a heuristic model of psychotherapeutic change that suggests that change involves not only diversity of IMs but also specific interactions between them (Gonçalves, Matos et al., 2009; Gonçalves & Ribeiro, 2012). So, according to this model, change starts with action, reflection and protest IMs, considered the most elementary forms of innovation. Although these three types of IMs represent important new ways of experiencing and understanding the problematic self-narrative, they appear to be insufficient for the development of a stable new self-narrative. The emergence of reconceptualization IMs (usually in the middle of the process), in contrast, assumes a central role in sustaining a meaningful change, being infrequent or inexistent in poor outcome cases. These IMs establish a contrast between the former and the new self-narratives and posits the person as the *author* of this self-transformation process. Reconceptualization also fosters the emergence of other action, reflection and protest IMs, connecting the different alternative experiences that are now emerging in client's life (Santos & Gonçalves, 2009). Finally, Performing change IMs tend to appear after reconceptualization and

represent the expansion of the change process to the future, as new experiences, projects and intentions emerge due to the self-transformation process.

3.3 Protonarratives

Theoretically, IMs are micro-narratives that involve the emergence of new narrative contents or provisory themes that contrast with the themes proposed by the problematic self-narrative. Some of these themes become recurrent in the course of the therapeutic process, being identified as protonarratives (Ribeiro, Bento, Salgado, Stiles, & Gonçalves, 2011).

From the standpoint of the Innovative Moments Model, the new theme or protonarrative might emerge in several types of IMs, from action to performing change. Thus, both protonarratives and IMs can be identified and classified in the therapeutic dialogue. While specific IMs are types of narrative processes, protonarratives are the specific contents that emerge within these IMs (Ribeiro, Bento et al., 2011). As an illustration, consider the same complicated grief client presented above, whose problematic self-narrative was centered on the inability to reconstruct life in a less painful way. Initially, IMs might be focused on 1) acknowledging the client's needs and expectations towards a different life, 2) investing in moments of well being, or 3) finding social support to construct a new reality of life. Suppose we observe recurrent IMs focused on the search for moments of well-being. The redundancy and repetition of this theme throughout the process may be understood as the emergence of a protonarrative, which differ from the rules embedded in the problematic self-narrative.

Protonarratives are not self-narratives yet. However, by comprising a new set of rules that revise the dominance of the problematic self-narrative (e.g. "Maybe there is something more than pain in this life for me, maybe I need to find it and fight for it"), protonarratives contain elements of new potential self-narratives.

Several protonarratives may emerge during the psychotherapeutic process. Some of them may become stronger and develop into a new self-narrative and others may fade away. Furthermore, there are many ways in which IMs and protonarratives may interact over time, designing different paths to self-narrative reconstruction. Hypothetically, progress toward a new self-narrative may be triggered by greater diversity of IMs and protonarratives throughout the process, considering narrative

flexibility as a central aspect in self-narrative reconstruction (Gonçalves, Matos et al., 2009; Ribeiro, Mendes et al., 2012). In contrast, rigidity of these processes would sustain the problematic narrative, inhibiting the emergence and expansion of alternative meanings (White & Epston, 1990). At the end, the new self-narrative may emerge from the dominance of a specific protonarrative or even from the combination between two or more protonarratives (Ribeiro, Bento et al., 2011).

The research strategy adopted in chapters II and III of this thesis involved tracking IMs and the themes expressed therein (*protonarratives)* in complicated grief, analyzing their dynamic interactions in cases with different symptomatic improvements.

3.4 Innovative Moments and Ambivalence: the re-emergence of the problematic self-narrative

In addition to their potential for change, IMs can also be understood as unfamiliar experiences that challenge client's problematic, but usual, way of functioning. Thus, associated with their potential for self-transformation, IMs also generate uncertainty and discontinuity from the usual, taken-for-granted meaning-making processes (Ribeiro & Gonçalves, 2010). As suggested by Hermans and Dimaggio, even though uncertainty "challenges our potential for innovation and creativity", it also "entails the risks of a defensive and monological closure of the self" (2007, p. 35). This defensive movement facing innovation has been addressed in recent studies using the IMCS, which show that in both poor-outcome cases (Santos, Gonçalves, & Matos, 2010) and in the initial and middle phases of good-outcome cases (Ribeiro & Gonçalves, 2011) clients tend to attenuate self-discontinuity (instigated by IMs elaboration) by returning to the familiar (problematic) self-narrative. Let's consider the following example of the same complicated grief client presented above to illustrate this phenomenon:

C: "I want to reorganize my life and search for new experiences [reflection IM], **but every time I try it I see how overwhelming this pain is** [re-emergence of the problematic self-narrative]".

In this example, the innovative content associated with the client's initiative to search

for new ways of organizing his or her life after the death of the loved one is attenuated by the re-emergence of the problematic self-narrative centered on how his or her overwhelming pain inhibits this change process and constrains his or her life.

The re-emergence of the problematic self-narrative may result in the disappearance of alternative ways of feeling, thinking, or behaving, sustaining self-stability. In some cases, this interchange between the problematic self-narrative and IMs keeps repeating itself, as every new IM is a new threat to self-stability that needs to be attenuated through the return to the problematic self-narrative. Thus, the client becomes trapped in a cyclical movement in which two opposite parts of the self keep feeding each other, which Valsiner (2002) has called as ‘‘mutual in-feeding’’.

According to Gonçalves and collaborators (e.g. Gonçalves, Ribeiro, Stiles et al., 2011; Ribeiro & Gonçalves, 2010) the process of “mutual in-feeding” might be conceptualized as a type of “resistance” to change in form of ambivalence. These authors also suggest that this response of ambivalence can be empirically explored through the identification of *return-to-the-problem markers* (RPMs; Gonçalves, Ribeiro, Stiles et al., 2011), which are utterances appearing immediately after an IM, attenuating it. Further description of the RPMs’ coding process is provided in chapters II and IV, as it was one of the methodologies used in these two studies.

Thus far, the phenomenon of ambivalence through the emergence of RPMs has been explored in different samples and therapeutic modalities (e.g. victims of intimate violence treated in narrative therapy, emotion-focused therapy and client centered therapy for depression (Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro, Mendes, et al., 2012; Ribeiro, Cruz, Mendes, Stiles, & Gonçalves, 2012). In general, these studies have emphasized the role of ambivalence as a natural part of the change process, associated with a mechanism of self-protection against the anxiety prompted by changing something familiar into something new (Engle & Holiman, 2002; Messer, 2002). This perspective is congruent with the constructivist conceptualization of “resistance” (Ecker & Hulley, 1996; Feixas, Sánchez, & Gómez-Jarabo, 2002; Fernandes, 2007; Fernandes, Senra, & Feixas, 2009; Mahoney, 1991), with a focus on client’s hesitation to change as an adaptive reaction to the threat of unpredictable experiences (Arkovitz & Engle, 2007; Kelly, 1955).

In chapters II and IV, I address how ambivalence emerges and progresses in clients with different clinical improvements in complicated grief, drawing attention to

the narrative processes involved in the transformation or maintenance of their self-narratives throughout the therapeutic process.

4 INTRODUCING THE CURRENT STUDIES

As Neimeyer, Prigerson and Davies (2002) observed, "the loss of an intimate attachment relationship through death poses profound challenges to our adaptation as living beings" (p. 238). Although the majority of individuals integrate this experience in an adaptive way, others may benefit from psychotherapeutic interventions that help them considering alternative ways to give meaning to this event (Neimeyer et al., 2010).

Evidence for the centrality of meaning reconstruction in the wake of loss supports this view, and suggests the relevance of constructivist-narrative techniques that foster self-narrative reorganization (Lichtenthal & Cruess 2010; Neimeyer et al., 2010). But how do clients progress from the maintenance of a problematic self-narrative toward a new and more flexible one? Which narrative processes are involved in this self-transformation process?

Gonçalves and colleagues (Gonçalves, Matos et al., 2009; Gonçalves, Santos et al., 2010) propose that narrative transformation in psychotherapy occurs through the emergence and expansion of *innovative moments*. As they pointed out, "as change starts to develop, innovative moments necessarily occur, as new voices come to the foreground and the formerly dominant ones are pushed to the background" (Gonçalves & Ribeiro, 2012, p. 83). The Innovative Moments Model (Gonçalves, Matos et al., 2009) directs our attention to those instances wherein clients contest the dominance of the problematic self-narrative in their lives and start to invest in a different reality.

This thesis presents a possible way to address narrative change in constructivist grief therapy according to the Innovative Moments Model. It explores how clients with different symptom improvement transform their problematic self-narratives by elaborating IMs across therapy. Additionally, it also explores how this investment in self-narrative transformation may be attenuated by a return to the problematic self-narrative, associated with a response of ambivalence in therapy. The clinical implications of this ambivalent response are also discussed.

I now briefly summarize the chapters of this thesis. The first chapter presents an intensive analysis of a good outcome case of constructivist grief therapy using the "Innovative Moments Coding System" (IMCS; Gonçalves, Ribeiro, Matos, et al., 2010; Gonçalves, Ribeiro, Mendes, et al., 2011). This study was our first attempt to apply the IMCS to this type of therapy, in order to analyze the process of narrative change in complicated grief. It also represented an important test of the feasibility and reliability of studying IMs' emergence and development in this therapeutic model. The studied case – an African American woman that lost her unborn daughter – was available from the American Psychological Association (APA) and included six constructivist grief therapeutic sessions conducted by Robert Neimeyer, PhD, from the University of Memphis, who authorized us to use the transcripts of the case and collaborated with us in studying narrative change in complicated grief from the perspective of the Innovative Moments Model. The transcripts of the six sessions were analyzed and coded by two trained judges. The results were compared with the results obtained in other samples and therapeutic modalities and with the hypotheses proposed by the heuristic model of change (Gonçalves, Matos & Santos, 2009).

Given the focused but limited scope of the first study, we proceeded by collecting a Portuguese sample of constructivist grief therapy in order to further explore the emergence and development of IMs in complicated grief. The next chapters present the studies developed with the cases of this sample, collected at University of Minho.

In order to be able to collect this sample, I started my contact with the meaning reconstruction approach to grief therapy in Memphis, collaborating with the "grief laboratory" of the Department of Psychology of the University of Memphis, oriented by Robert Neimeyer, PhD (from February to March 2009). My participation in his constructivist grief therapy classes and the work with his research group in analyzing the case presented in chapter I were the first steps in this process of doing and studying grief therapy. After this initial phase, I continued the training process by doing constructivist grief therapy with two bereaved grief Portuguese women at the University of Minho, being oriented by Eugénia Ribeiro, PhD, who had 18 years of experience in constructivist therapy. The Portuguese sample collection started after this training process. The supervision with Eugénia Ribeiro continued until the end of the sample collection, with a periodicity of two to three times per month.

The second chapter explores how two constructivist grief clients transform

(through the elaboration of IMs) or maintain (through the recurrence of RPMs) their problematic self-narratives throughout therapy. In general, this study aimed to add relevant information to the existing knowledge of meaning making processes in grief therapy, by exploring change and ambivalence in two grief cases with different symptom evolution (a recovered case and an improved but not recovered case). Furthermore, it also explored the themes or protonarratives associated with change (IMs) and ambivalence (RPMs). It is important to note that the studies with the Portuguese sample were conditioned by the timing of sample collection. By the time study 2 (chapter II) was performed, these two cases were the only ones whose interventions had already been completed.

At the time of studies 3 and 4 (chapters III and IV, respectively) a total of six cases had already been collected and fully transcribed, which gave us the opportunity to further explore the emergence of IMs and RPMs in a larger number of complicated grief cases. Thus, chapter III presents the analysis of IMs in a sample of six Portuguese bereaved women, examining the association of IMs to the severity of grief symptomatology. In general, the purpose of this study was to investigate how IMs – as opportunities for self-transformation – occur throughout therapy and how their emergence and expansion were associated with the themes "Integration" and "Proactivity", identified in study 2 as relevant processes in loss adaptation.

Finally, in order to further understand the phenomenon of ambivalence in constructivist grief therapy, we investigated IMs attenuation (or emergence of RPMs) in the six collected cases (chapter IV). In fact, studies 3 and 4 are complementary, as the coding of RPMs required the previous coding of IMs. We decided to present them as different studies in order to provide an intensive analysis of both processes (change and ambivalence). However, it is important to highlight the continuity between these two studies.

Before concluding this introduction, I would like to acknowledge some redundancy throughout the chapters given that each one gives a brief description of IMs conceptualization of change and characterizes the IMCS, its findings, and the model of narrative change developed in this perspective. This is due to the format of the dissertation, since each chapter corresponds to an independent and self-contained paper.

CHAPTER I

INNOVATIVE MOMENTS IN GRIEF THERAPY: RECONSTRUCTING MEANING FOLLOWING PERINATAL DEATH

CHAPTER I

INNOVATIVE MOMENTS IN GRIEF THERAPY: RECONSTRUCTING MEANING FOLLOWING PERINATAL DEATH[2]

1 ABSTRACT

This article presents an intensive analysis of a good outcome case of constructivist grief therapy with a bereaved mother, using the *Innovative Moments Coding System* (IMCS). Inspired by White and Epston's narrative therapy, the IMCS conceptualizes therapeutic change as resulting from the elaboration and expansion of *unique outcomes* (or as we prefer, *innovative moments*), referring to experiences not predicted by the problematic or dominant self-narrative. The IMCS identifies and tracks the occurrence of five different types of innovative moments: *action*, *reflection*, *protest*, *reconceptualization*, and *performing change*. Results documented the process of meaning reconstruction over the six sessions of treatment, and demonstrated the feasibility and reliability of analyzing narrative change in this form of grief therapy, opening it to comparison with other approaches.

2 INTRODUCTION

Life changes after a major loss can be revolutionary, requiring a drastic reordering of personal priorities and major new capacities and roles. Reconstructing a world of significance in the wake of bereavement frequently involves an active process of self reorganization and adaptation to a new life-story (Neimeyer, 2000). This reconstruction can result in a deep self-narrative transformation. The self-narrative can be defined as "a cognitive-affective-behavioral structures that organizes the 'micro-narratives' of everyday life into a 'macro-narrative' that consolidates our self-understanding, establishes our characteristic range of emotions and goals, and guides our performance on the stage of the social world" (Neimeyer, 2004a, pp. 53-

[2] This study was published in the Journal *Death Studies* with the following authors: D. Alves, I. Mendes, M.M. Gonçalves, & R.A. Neimeyer.

We gratefully thank to Robert Neimeyer for generously authorizing us to use the transcripts of the case of Cara.

54). Thus in daily life we create narratives to give meaning to events, integrating them into an evolving story that gives them order and thematic significance. Importantly, the self-narrative also restrains the emergence of new meanings that can transform and invalidate the current meaning system (Gonçalves, Matos, & Santos, 2009) in order to create a sense of predictability in a rather unpredictable world. As Bruner (1986) suggests, narrative construction is a potent form of assimilating events that are non-canonical, rendering them interpretable and meaningful. Major losses threaten these efforts at stability and coherence, however, prompting significant revisions to our prior meaning system (Neimeyer, 2002). A good deal of research with bereaved parents (Keesee, Currier, & Neimeyer, 2008; Lichtenthal, Currier, Neimeyer, & Keesee, 2010), older widows and widowers (Coleman & Neimeyer, 2010), survivors of the violent death of a loved one (Currier, Holland, Coleman, & Neimeyer, 2007) and bereaved young people (J. Holland, Currier, & Neimeyer, 2006; J. M. Holland, Currier, Coleman, & Neimeyer, 2010; Neimeyer, Baldwin, & Gillies, 2006) supports the view that an inability to "make sense" of the loss by assimilating it into a personal framework of meaning is associated with complicated, protracted grief symptomatology. At its worst, the story of the loss may become the "dominant narrative" of the person's life, effectively resisting restructuring along more hopeful lines (Neimeyer, 2006a). Accordingly, an anguishing search for constructive meaning in what appears to be a senseless loss can be viewed as a critical focus of grief therapy (Neimeyer, 2011; Neimeyer & Sands, 2011).

But how do clients in grief therapy integrate loss and reconstruct their self-narratives? Theoretically, constructivist grief therapy offers a reflective context for helping clients symbolize, articulate and renegotiate the meanings on which they rely (Neimeyer, 1995), in a context marked by high "presence" on the part of the therapist and subtle co-construction of meaning in a vividly experiential, rather than "cognitive" therapeutic climate (Neimeyer, 2009). To date, several illustrative case studies of grief therapy as meaning reconstruction have appeared in print (Neimeyer, 2001; Neimeyer & Arvay, 2004; Neimeyer, Burke, Mackay, & Stringer, 2010) and in video demonstration (Neimeyer, 2004b), and controlled outcome research on narrative techniques in grief therapy have been encouraging (Lichtenthal & Cruess, 2010; Wagner, Knaevelsrud, & Maercker, 2006). However, no empirical analyses of the process of constructivist grief therapy have yet been published. Therefore it was our purpose, through the intensive analysis of a single case across a full six-session

therapy, to illustrate how a life story is reconstructed in the context of tragic bereavement.

According to Gonçalves and colleagues (Gonçalves et al., 2009; Gonçalves, Santos et al., 2010) narrative transformation in psychotherapy occurs through the emergence and expansion of moments of novelty, known as *Innovative Moments (*IMs). The concept of IM was inspired by White and Epston's (1990) idea of "unique outcome," referring to experiences outside the influence of the problematic or dominant self-narrative (e.g. guilt – "There's a lot of things making me feel like I'm a bad person"). An IM emerges every time a person thinks, behaves or feels in a different way from what the problematic narrative suggests (e.g., "*I don't want to live like that, I want to be able to enjoy life… I deserve that*."). As IMs are micro-narratives, their analysis is relevant to understand how clients integrate new experiences into their former meaning system and how the narrative elaboration and development of such IMs eventually consolidate a new self-narrative. Thus, the amplification of IMs plays a pivotal role in the promotion of self change processes, producing a disruption in the problem-saturated story of loss, prompting alternative meanings and eventually creating a new self-narrative (Gonçalves et al, 2009).

In order to track the emergence of IMs throughout the psychotherapeutic process, a qualitative method of data analysis was developed – the *Innovative Moments Coding System* (IMCS, see Table I; Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011). This system allows identification of five types of IMs:

1. *Action* IMs refer to specific new behaviors that are intentionally enacted by the client and are different than one would expect, keeping in mind the constraints that the problematic self-narrative imposes on the client's behavior.

2. *Reflection* IMs are those events in which the client understands something new that contradicts or challenges the problematic self-narrative.

3. *Protest* IMs are actions (like action IMs) or thoughts (like reflection IMs) that express a direct refusal of the problematic self-narrative and its assumptions. It results in more proactive stance in therapy.

4. *Reconceptualization* IMs represent a complex form of meta-reflective process that indicates that the person not only understands what is different about him or herself, but can also describe the process that was involved in this transformation. These IMs involve three components: the self in the past (problematic self-narrative),

the self in the present (emerging alternative self-narrative), and the description of the processes that allowed the transformation from the past to the present.

5. *Performing change* IMs include new projects, aims, activities or experiences that were not possible before, given the restrictions imposed by the problematic self-narrative. They represent a performance of the change process and may function as a projection of new intentions, purposes, and goals that shape the emergence of a new self-narrative.

Table I. 1: Categories of Innovative Moments with Examples

	Contents	Examples (Problematic narrative: depression)
Action	• New coping behaviors facing anticipated or existent obstacles; • Effective resolution of unsolved problem(s); • Active exploration of solutions; • Restoring autonomy and self-control; • Searching for information about the problem(s).	*C: Yesterday, I went to the cinema for the first time in months!*
Reflection	***Creating distance from the problem*** • Comprehension – Reconsidering the problem's causes and/or awareness of its effects; • New problem(s) formulations; • Adaptive self instructions and thoughts; • Intention to fight problem's demands, references of self-worth and/or feelings of well-being.	*C: I realize that what I was doing was just not humanly possible because I was pushing myself and I never allowed myself any free time, uh, to myself … and it's more natural and more healthy to let some of these extra activities go…*
	Centered on the change • Therapeutic Process – Reflecting about the therapeutic process; • Change Process – Considering the process and strategies implemented to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change); • New positions – references to new/emergent identity in face of the problem.	*C: I believe that our talks, our sessions, have proven fruitful. I felt like going back a bit to old times. It was good, I felt good, I felt it was worth it.*
Protest	***Criticizing the problem(s)*** • Repositioning oneself towards the problem(s).	*C: What am I becoming after all? Is this where I'll be getting to? Am I going to stagnate here!?*
	Emergence of new positions • Positions of assertiveness and empowerment.	*C: I am an adult and I am responsible for my life, and I want to acknowledge these feelings and I´m going to let them out! I want to experience life, I want to grow and it feels good to be in charge of my own life.*

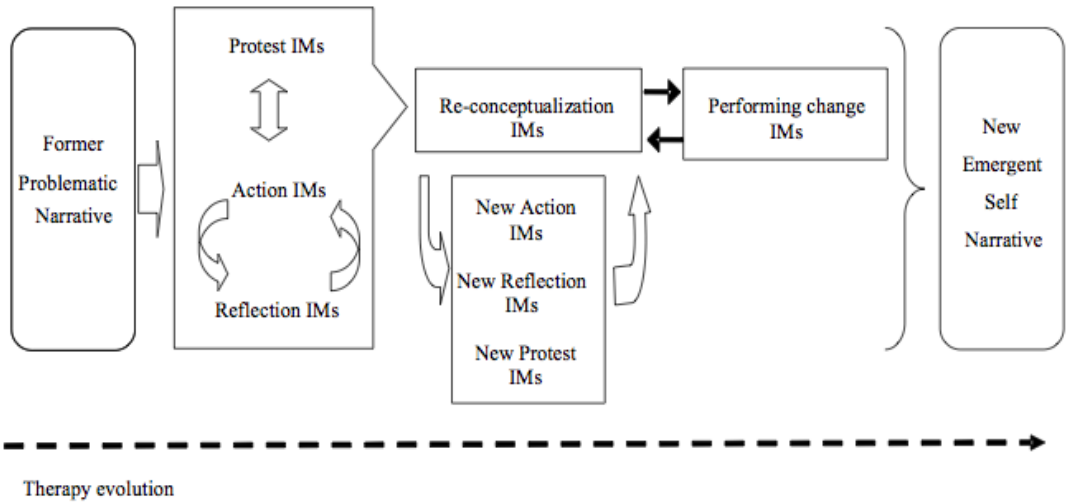
Reconceptualization	Reconceptualization always involve two dimensions: • Description of the shift between two positions (past and present); • The process underlying this transformation.	*C: You know… when I was there at the museum, I thought to myself: you really are different… A year ago you wouldn't be able to go to the supermarket! Ever since I started going out, I started feeling less depressed… it is also related to our conversations and changing jobs…* *T: How did you have this idea of going to the museum?* *C: I called my dad and told him: we're going out today!* *T: This is new, isn't it?* *C: Yes, it's like I tell you… I sense that I'm different…*
Performing Change	• Generalization into the future and other life dimensions of good outcomes; • Problematic experience as a resource to new situations; • Investment in new projects as a result of the process of change; • Investment in new relationships as a result of the process of change; • Performance of change: new skills; • Re-emergence of neglected or forgotten self-versions.	*T: You seem to have so many projects for the future now!* *C: Yes, you're right. I want to do all the things that were impossible for me to do while I was dominated by depression. I want to work again and to have the time to enjoy my life with my children. I want to have friends again. The loss of all the friendships of the past is something that still hurts me really deeply. I want to have friends again, to have people to talk to, to share experiences and to feel the complicity in my life again.*

Note. From *The Innovative Moments Coding System: A coding procedure for tracking changes in psychotherapy*, by Gonçalves, Ribeiro et al., 2010. Adapted with permission.

The present analysis of a full six-session grief therapy organized along meaning reconstruction lines will trace the emergence of each of these specific types of IMs.

Results from previous hypothesis-testing studies analyzing the emergence of IMs in a variety of samples (see Matos, Santos, Gonçalves, & Martins, 2009; Mendes et al., 2010; Gonçalves, Mendes et al., 2011), and intensive single-case studies (Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Ribeiro, Gonçalves, & Ribeiro, 2009; Santos, Gonçalves, Matos, & Salvatore, 2009; Santos, Gonçalves, & Matos, 2011) have allowed the construction of a heuristic model of narrative change (see Figure 1).

Figure I. 1: Heuristic Model of Change



Note. From *Narrative therapy and the nature of "innovative moments" in the construction of change* by Gonçalves, Matos, & Santos, 2009. Adapted with permission.

According to this model, action and reflection IMs initiate the process of change, emerging when the person starts wondering about the characteristics of an alternative life (reflection IMs) or behaving differently (action IMs). Reflection IMs can spur new behaviors (action IMs) or, alternatively, new behaviors can stimulate reflection IMs. As suggested by Gonçalves et al. (2009), multiple cycles of action and reflection may be required before the client and significant others notice the emergence of meaningful life novelties. Protest IMs can also emerge from the beginning of therapy, creating a "proactive position" (e.g., "I don't want my life to be like this anymore!"), or it can appear only after the expansion of reflection and action IMs. The outset of therapy is usually characterized by these three types of IMs. Reconceptualization commonly emerges in the middle of therapy with an increasing tendency until termination and seems to play a critical role in sustaining change, given its dual function. First, it gives coherence and structure to prior actions, reflections and protest IMs, given the contrast between the past and present self; that is, a contrast between a problematic narrative and one characterized by the emergence of IMs. Second, it fosters an understanding of the shift that enabled this transformation, creating a meta-position concerning the change process or a position of authorship (see Dimaggio, Salvatore, Azzara, & Catania, 2003, on the importance

of meta-cognition in therapeutic change). That is, not only is something new and meaningful taking place, but also, and even more importantly, the person is clearly in charge of that change. Reconceptualization IMs stimulate new action, reflection and protest IMs; which in turn prompt new reconceptualizations. Finally, performing change IMs emerge, representing the expansion into the future of the emergent self-narrative (e.g., engagement in new projects), ensuring to the client that the new narrative has a future. This study is the first to use this coding system and model of change with a case of grief therapy, thus representing an important test of the applicability of IMCS and its heuristic model in the area of bereavement.

2.1 The present study

This research analyzes the process of narrative change in constructivist therapy with one good outcome case of a client with complicated grief. All six therapy sessions were transcribed and coded using the IMCS in order to track the IMs that emerged throughout the therapeutic process. The fourth author served as therapist, and was uninvolved in the coding of the sessions, which was performed by a highly experienced research group in another university. Readers interested in viewing the entire course of this therapy, both with and without process commentary by the therapist, can find it in commercially available DVD format (Neimeyer, 2008).

Cara was a 37 year old African American woman, referred to individual grief therapy organized along constructivist lines (Neimeyer, 2006b; Neimeyer et al., 2010), 6 months after the stillbirth of her daughter (who died *in utero* at 7 months of gestation). She was married and had two small children and an adolescent stepdaughter, Jasmine, whose unplanned and undisclosed pregnancy was detected only a short time after the death of her sister, leading to major family complications. This theme became one focus of Cara's therapy, toward the end of which Jasmine gave birth to a healthy daughter. Cara met criteria for complicated grief or prolonged grief disorder (Prigerson et al., 2009), assessed using the Inventory for Complicated Grief (ICG, Prigerson & Jabobs, 2001) administered at the outset of treatment. This case was considered a good outcome as the client's score on the ICG dropped substantially after the 6 sessions of therapy, such that she no longer met diagnostic criteria for the disorder. In her first clinical interview Cara recounted the troubling events of her baby's death, which she first suspected the day after Mother's Day

when the previously active child within her became quiescent, sliding lifelessly in her womb as she rolled over in bed. Cara immediately sought medical consultation, where the probability of her child's death was confirmed, and the stillborn infant was delivered the next day. Though originally planning to name her "Lorraine" after a beloved aunt who had functioned as a second mother, the couple decided to christen her "Spirit," because "that is how she came to us, as a spiritual being rather than a living child." Compounding the tragedy, a few hours after informing Aunt Lorraine of her daughter's death, Cara received the news that Lorraine herself had died, apparently of a heart attack. Cara and her husband therefore added Lorraine as a middle name for their deceased child, to honor that lost love as well.

In her first session of therapy, some seven months following Spirit's birth and death, Cara described the tragedy as an unexpected event that "*kind of threw everything into a tailspin*." In the midst of an otherwise orderly and hopeful life, Cara found herself plunging down on "a rollercoaster ride" of emotion, which deeply disturbed her sustaining life projects. In her own words, "*I had everything planned out, I just didn't have this planned. I was to finish school by June 26th, she's due July 9th. I was done with my degree and I had babysitters lined up as well as a job, and now all that is gone. School's going to take me two semesters more now…. I'm not working…. And 4 days later I find myself in the hospital, losing what I gave up everything for*." Cara's problematic self-narrative suggested that, since the stillbirth of her daughter, her life became a mixture of emotions ruled by pain, guilt and disbelief that seriously challenged her personal, family and social functioning. As a result, Cara constricted her world by avoiding both her stepdaughter and best friend for months, as each carried her own baby to term.

Early in therapy Cara alternated between abject grief for her own loss and resentment about Jasmine's pregnancy, a reality for which she felt "*totally unprepared*." As she noted, "*It seems so unfair… the fact that I'm in a place to care for a child and mine is taken. There is some jealousy, there is some anger, just sadness involved with the entire thing*." She therefore remained locked in a conflict between her role as parent of a living child, with a felt obligation to take care of her stepdaughter, and as the parent of Spirit, to whom she owed a duty of grief. As she stated in the first session "*I feel really guilty because I almost envy her pregnancy even though I know she shouldn't, she shouldn't be pregnant, you know, and then I think that is so unfair…. This is going to remind me every time I look at her child*

that mine is no longer here." Stifling her tears in the presence of others, Cara struggled to maintain a culturally valued role of being a "strong woman," retreating to her room and to her private grief several hours every day, and disengaging from a world that caused her such pain.

3 METHOD

3.1 Researchers

The primary researcher working with the case of Cara was a woman in her middle twenties doing her PhD dissertation, integrated in a team of researchers studying therapeutic change processes using the IMCS. Another PhD student trained in this coding system also participated in the single-case study by independently coding 100% of the sample. Neither was a mother at the time of this study.

3.2 Measures

The case was coded using the IMCS (Gonçalves, Ribeiro et al., 2011). We give examples below of the different types of IMs that emerged throughout therapy.

3.3 Procedures

Following a careful reading of all the verbal material contained in the transcripts, the coders defined consensually the characteristics of the problematic self-narrative, taking into account the client's discourse. In this case the major problem domains included Cara's inability to deal with the loss of her baby, her guilt related to her baby's death and her stepdaughter's pregnancy, her incapacity to reinvest in her previous projects (work, school) and the inability to face "triggers" associated with pregnancy (expectant women, photographs in her obstetrician's office, newborns nursing in restaurants). Therefore, each instance in which Cara challenged these difficulties in any form (actions, feelings, thoughts) was considered an IM.

Each session was coded independently in terms of IM type (e.g., action, reflection) and its beginning and end to calculate its "salience." This index indicates the percentage of text in the session occupied by a specific IM (e.g., reflection), computed by calculating the number of words (both client's and therapist's) involved in each type of IM, divided by the total number of words in the transcript of the

session. The coders also calculated the index of overall salience for the IMs in the entire therapy and for each IM category.

Sessions were coded in a sequential order from the first to last, considering both therapist and client turn taking, as we believe the process of change is co-constructed by both parties (Neimeyer, 2002). Hence, IMs are coded when the client elaborates on questions or tasks suggested by the therapist, but not in cases in which the therapist merely proposes a task or a question containing a novelty that is denied or not elaborated by the client.

3.3.1 Training

The coders were trained by the authors of the manual in weekly meetings with a larger cohort of trainees. Between meetings they coded psychotherapy transcripts until they consistently met criteria for inter-coder reliability. The process of training included discussing the manual with the authors, coding transcripts from different samples, discussing disagreements and misunderstandings in the process of coding until a consensus among every member was established. At the end of the training period coders' reliability was assessed by comparing their codes with the codes of expert judges in a set of randomly selected excerpts of dialogues of therapeutic sessions. They were considered to be reliable and able to engage in coding research material once they achieved a Cohen's kappa higher than .75.

3.3.2 Inter-coder Reliability

The inter-coder percentage of agreement for salience was of 89%, reflecting high consensus in the number of words coded as IMs across the 6 sessions. Regarding their agreement for the specific type of IM, Cohen's kappa was .80, again indicating strong agreement between coders (Hill & Lambert, 2004).

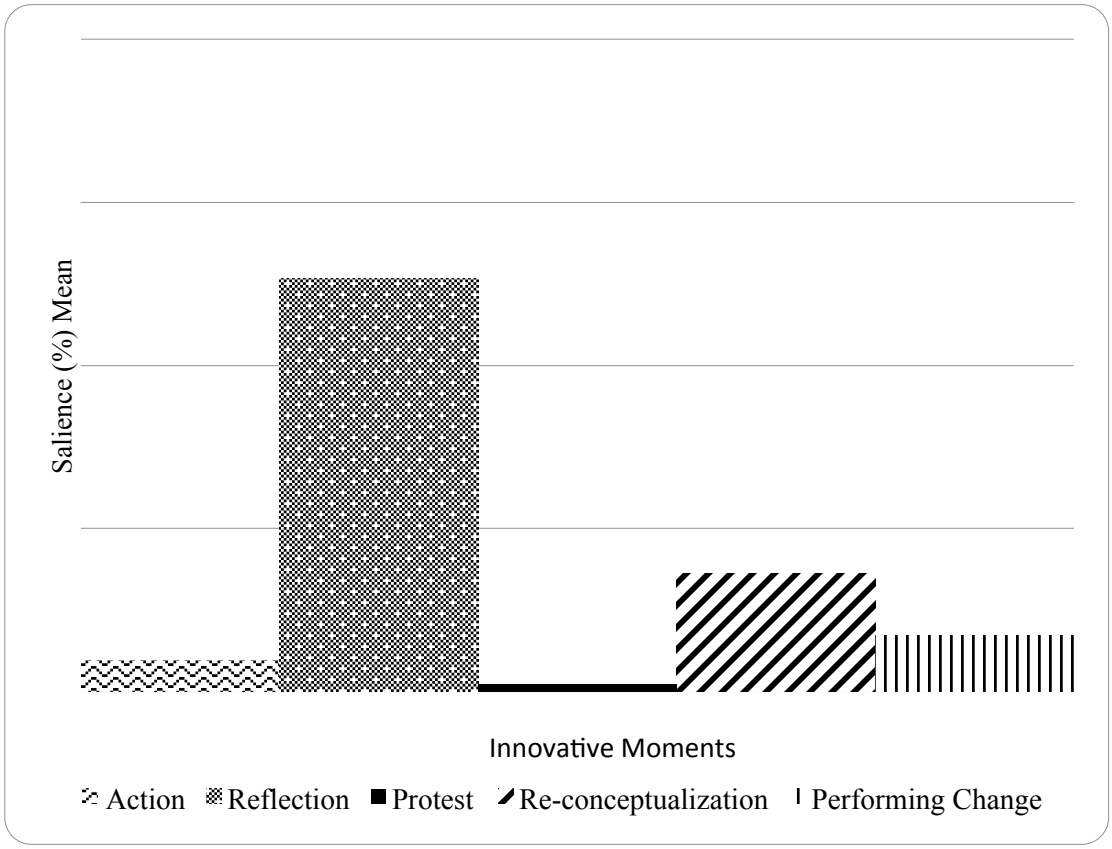
4 RESULTS

4.1 Overall Findings

Cara and her therapist spent nearly 20% of all therapeutic dialogue involved in the elaboration of IMs (overall salience for all the five categories). In general, salience increased across the therapy. The category with highest salience was

reflection (12.7%) followed by reconceptualization (3.6%). Performing change occupied 1.7% of the entire therapy, while action and protest occurred less frequently (.9 and .2, respectively) (see Figure 2). Salience of IMs fluctuated across sessions, with the third showing the lowest salience (8.6%), and the sixth displaying the highest (32.2%).

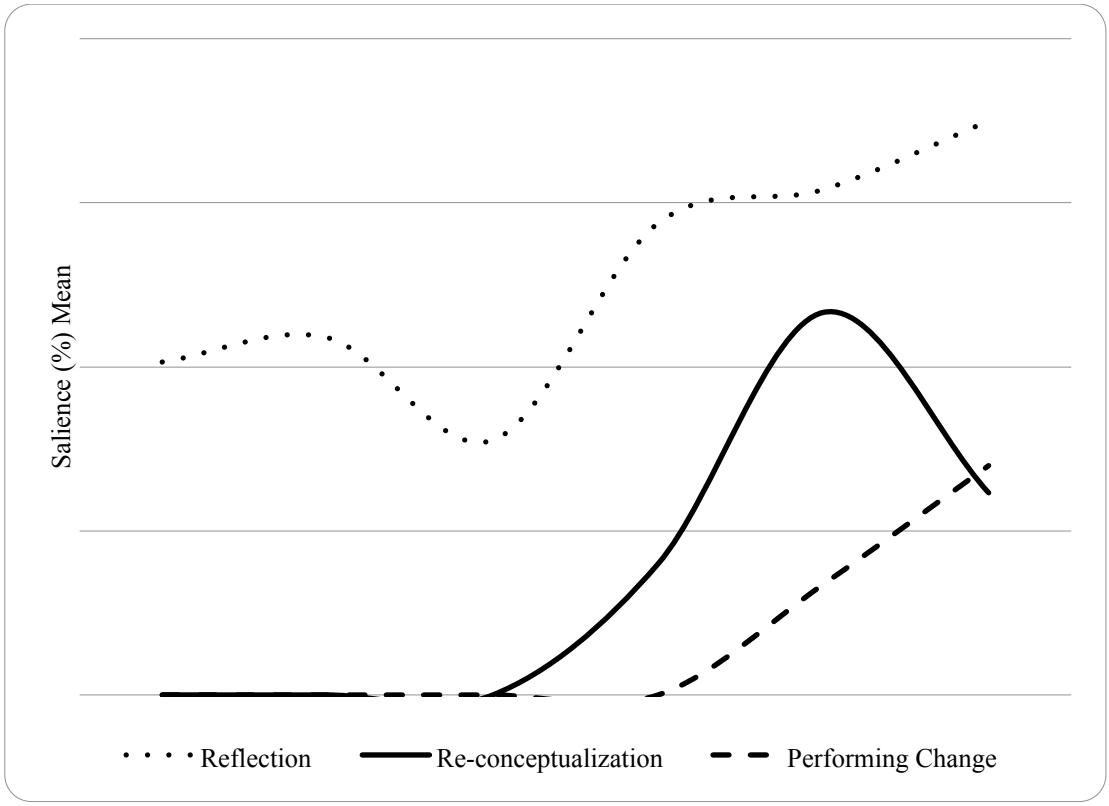
Figure I. 2: Overall salience of IM types throughout the therapeutic process.



4.2 Emergence of IMs types across the course of therapy

A careful analysis of Cara's therapeutic process highlights the specific contribution of each IM over the course of the meaning reconstruction activity. Figure 3 depicts the evolution of reflection, reconceptualization and performing change IMs, as they were the most predominant categories in this case.

Figure I. 3: Evolution of reflection, reconceptualization and performing change IMs throughout the therapeutic process.



Action and protest IMs are not represented in the figure given their low salience, but their evolution is described below, in order to fully represent the client's IMs progression throughout therapy.

Action IMs. Action IMs were present in all sessions but had a low salience value throughout. They began to appear at session 1, when Cara told her therapist that she and her husband decided to name her unborn baby Spirit. Despite its low salience, this action IM was very important for Cara, as it represented a new coping behavior in the wake of an anguishing loss, reinforcing the spiritual bond between her and her baby. In session 5, Cara related an episode in which she was able to make a telephone call to a pregnant friend who she had been avoiding for months: "*I was able to leave her a message. She has not returned my call yet but I did apologize to her that it had been so long since I spoke to her, and I told her I loved her and [to] give me a call*." In session 6, Cara let her therapist know that she begun to build an active closeness with her stepdaughter and her baby: "*I have actually spoken to Jasmine and asked her about her and the baby and just [make] general conversation.*

'Is she sleeping all the time now?' or 'Is she keeping you up a little?"', chuckling at the image of Jasmine wrestling with the predictable challenges of early motherhood. These examples emphasize the emergence of an active exploration of new ways of dealing with her pain and isolation, in conjunction with the restoration of important roles within the family and the wider social context. All such IMs represented specific actions, in which the problematic self-narrative that emerged after the loss was challenged at a behavioral level.

Reflection IMs. Reflection IMs emerged from the beginning of therapy and increased gradually over time. Their salience in session 1 was 10.2%, increasing progressively through session 4 (14.4%) to session 6 (17.5%). From the outset, Cara and her therapist invested in reflection IMs around her experience of self reconstruction after loss. In session 1, she stated, "*I guess my main reason for being here* (in therapy) *is to help get some understanding as to how to move on now. You know, I can't keep cutting people off. There are going to be babies born every day and people getting pregnant all the time, and I've got to find a way to deal with it without falling apart*."

The content of reflection IMs across therapy focused on new intentions to deal with the problem (e.g. "*get a job and work full time and then go back to school in the winter after I've learned to deal with this a little bit better*"). Likewise, such moments arose as the therapist prompted meaning reconstruction around the problem, encouraging Cara's quest for new significance. For example, in session 3, reviewing for the first time the photos of Spirit's birth, Cara and her therapist engaged in a strong reflective processing of the meaning of Spirit's brief life inside Cara, as reflected especially in the reading of her eulogy statement, written by Cara and her sister, entitled "Born Still":

> *C: This was what I put on the back of her obituary and I think that was probably the best I could find to explain how I felt. I and my sister wrote it. You can read it.*
>
> *T: "Born still" (title). Seven long months I carried you, I felt you kick more than any before you ... After my strong laboring you came and did not cry, did not breathe. We had not expected this. The record will say that you did not live and will register you as a stillborn child but for me you lived all that time in my womb. I felt you kick and so I know that you were there with me. Now I*

know that you are in the grace of God, in his sight, his perfect little angel. I know that for us you were born still. We will carry you with us forever, my child, my love. You will always be a part of all of us. You were always ours and you are ours now. Death and life are the same. You were born, still – Mommy and Daddy".

C: That's really the only, the best way to describe how I felt how I feel.

T: Yes, the idea that she was born. Affirming the life she had within you, and the way you carried her, not only then but the way you carry her now….

Cara's commitment to this meaning-making process gives voice to an interesting new narrative that reaffirms her intent to hold Spirit in her own life story, asserting that in spite of Spirit's death, she was still a living being and still had personhood. The elaboration of this IM in the session represented a powerful construction of meaning around the life and death of her child.

The therapeutic process continued developing around Cara's investment in new ways to re-narrate specific aspects of Spirit's brief passage through life, reclaiming a measure of authorship in the midst of an unchosen experience. In session 4, she gave further attention to an ultrasound of her baby at 4 months of gestation, first shared at the end of the review of photographs in the previous session. While representing a clear image of Spirit in profile, the ultrasound image also contained an ominous image of a woman in a flowing robe, with clearly discernible hands and face, seemingly moving across the picture. For Cara, and still more for her "emotional" sister, this outline suggested a ghost-like being carrying a malevolent meaning, a harbinger of the death of her child that would soon follow. At the suggestion of her therapist, Cara drafted a letter addressed to that image as therapeutic homework, in which she powerfully articulated the burning existential questions that were in her heart, offering it to the therapist to read aloud in the session that followed: "*C: What - are you? Were you there to take my baby? (...) Some say you're an angel, some say I'm imagining you, but that can't be true. You weren't there in human form but there all the same. Did I do something wrong? There's nothing I can do and nothing that no one can do."* In session 5, one week later, Cara spontaneously reported reconstructing the meaning of this image with one of her aunts, a spiritual mentor figure for her, into an ancestral spirit guide who came to escort her child safely to heaven. This novelty provided an alternative interpretation of this chapter of her loss, one that opened a path to the spiritual resolution she gradually achieved:

C: I was actually thinking about the ultrasound image and I don't know what exactly it was, but it was something. Even though I had sinister feelings associated with that picture, I think it's mostly my anger about what happened.... I think it was not an evil being.

T: That even though there was plenty of understandable anger at this outcome, it wasn't kind of out to injure and hurt but had some other purpose?

C: Well my aunt... she studies theology, and she says that when you die someone always comes to get you. You never go alone. Somebody... one of your family members, one of your ancestors will come to get you.

During the last phase of the therapy, reflection IMs continued to focus on strategies to deal with the demands of the grief, allowing Cara and her therapist to differentiate new self-positions. In session 6, when the therapist reflected on the importance of "freely and fully assenting" to life transitions, Cara went on to elaborate a significant reflection IM regarding her new emergent self, contrasting this new position with the former problematic self-narrative: *"Exactly like someone getting up going to work every day or someone getting up, going to do what they love to do. It is a big difference, because now instead of looking just at the nature of what I've been in, I am now looking into other options, just seeing what needs need to be met."*

Protest IMs. Protest IMs presented the lowest salience of all IM categories identified in this case. This type appeared only twice across therapy, when Cara initially defied family expectations to support her pregnant stepdaughter, as it is illustrated in the next example:

T: If you were to just kind of do a scan of what is emotionally important for you in this… what would be the things that really stand out as things that you need attention to now?

C: You know, um, I think that my husband as well as his mother could be more understanding of my withdrawal from Jasmine. Hmm… because it has upset them that I didn't want to see her. But I keep trying to explain it's not that I don't want to see her it's that I'm not ready to see any pregnant woman.

Reconceptualization IMs. Reconceptualization IMs emerged for the first time in session 4 with a low salience, increasing dramatically in session 5 and decreasing

slightly in session 6. Beginning in session 4, Cara started to attend to the contrasts between her former and current ways of dealing with her mourning process. In session 5, an interesting example emerged concerning the way Cara highlighted all the strategies that helped her to change, assuming her authorship of this transformative narrative:

T: You are doing something differently with the stress of that grief that is letting the physical manifestation go away. What do you think it is? What makes a useful difference for you there?

C: Maybe it is dealing with it, as opposed to before [when] I kind of did shut down. I did spend a lot of time in my room crying. My mom kept telling me, "You need to stop because it is going to start manifesting itself in another way…." And I think she was right, because once I did start back to work and the prospect of going back to school was there, they subsided. I have been talking to you, I have been talking to my sister, the exercises you had me doing…. And it has been, I have been finding more creative ways to let it out other than just sitting in my room crying.

T: That is a very nice phrasing. "I have been finding more creative ways," Right? Creative ways…. What do you think you are creating with these ways?

C: A way to release the stress without breaking down. A way to not just crawl in my bed and be upset all day. Just getting back to life. At that point [at the beginning of therapy] I was home with no work, no school, no prospect of either. And I have five classes to finish and was worried that I was not going to be able to do that. Not working…. So I think that was a big problem, the whole work, school and sitting at home every day…. I went right back to smoking cigarettes, so I think that I was causing myself physical problems, by the way I was grieving.

T: So there was a time when you kind of turned inward, and even relied upon some ways of coping that were not working for you, they were working against you. And then it seems like maybe by degrees, or in some particularly difficult moments, you decided to turn a corner and go a different direction.

C: Well, I had to get my life back in order. I looked for a job and it seems like I just could not find anything compatible with going to school. [Now] I've

started somewhere else that took me away from home all day.

In the last session of therapy, despite the decrease of reconceptualization IMs, Cara continued to narrate the way she gave meaning to the self changes occurring through the therapeutic process in the form of IMs featuring reflection and performance of change.

Performing change IMs. Performing change IMs emerged at session 5 (with a low salience, 3.4%) and built progressively in session 6. In this final phase of therapy, Cara and her therapist engaged in an intense exploration around her new personal meanings and the way they permitted a new experience of the mourning process. The specific moment when Cara was holding Samaya (Jasmine's baby), for the first time, and looking forward to rocking her in the chair that she had bought to rock Spirit, was an remarkable example of a new way of performing her new story. As the therapist noted, it symbolized vividly how she had room enough in her heart for both babies, as well as for Jasmine as she sought to help her become "the great young lady" she could be:

T: Can you imagine some of the ways in which you will be able to do something with them (Jasmine and Samaya) on the weekend?

C: She needs to get a little bit bigger but I can probably hold her.... I have been dying to rock her for some reason ....

T: And to be able to do that in a chair that really was purchased for Spirit. You will be rocking both of these children in the same moment.

C: So, yeah, I've been dying to do that. I think I will when she comes over."

In addition, the elaboration of Cara's investment in new projects as a result of the self reconstruction process facilitated, through the interplay between performance and reflection, engagement with new self experiences and life projects. In fact, by the end of therapy, Cara was considering a new career option in human services:

T: And you are finding a clearer image of what it is you love to do, what has purpose and meaning for you?

C: Making an impact in helping people, in whatever way that I can help. Anything that I have ever wanted to do in life always had something to do with helping other people.

In passages like these, Cara underscored her capacity for performing change and embarking on future projects that are coherent with her pre-loss sense of self.

5 DISCUSSION

The study of Cara's case with the IMCS reveals that the pattern of IMs in constructivist grief therapy shows similarities with those found in previous studies of good outcome cases conducted from such theoretical standpoints as narrative therapy (Matos et al., 2009), emotion-focused therapy (Gonçalves, Mendes et al., 2010; Mendes et al., 2010), client-centered therapy (Gonçalves, Mendes et al., 2011), or constructivist therapy focused on implicative dilemmas (Ribeiro et al., 2009). As in other successful therapies studied, reflection IMs have a significant salience throughout the entire process and seem to support the elaboration of other novel developments, given their centrality. The usual emergence of reconceptualization at the middle stage of therapy is also found, showing an increasing salience during session 5, decreasing in the last session. Performing change IMs emerge in the final phase of therapy, after reconceptualization, increasing in prominence until therapy is completed. Action IMs also emerge in this case but with a reduced salience. However, this low salience is also typical of other good outcome cases, in which action IMs prompt other IMs, more centered on meaning making (e.g., reflection, protest), which usually invite more extensive elaboration (Santos et al., 2009). As in constructivist therapy generally, vividly experiential work (e.g., through engagement in action) is followed by meaning-oriented consolidation, perhaps securing and anchoring preliminary behavioral changes that might otherwise be fleeting (Neimeyer, 2009). Thus, Cara's change process is globally congruent with the narrative model of change presented earlier in this paper. Cara is actively seeking and implementing a new orientation in a life that has been disrupted by her tragic loss, and is beginning to discern a larger meaning in her suffering. This encourages the emergence of new strategies to deal with the experience of mourning.

The great majority of Cara's IMs are situated in the field of meaning, in the form of reflection and reconceptualization IMs. In keeping with a meaning reconstruction approach to grief therapy (Neimeyer & Sands, 2011), all of these innovative meanings reflect Cara's active search for significance following this adverse experience. Perhaps these results are potentiated by the specific change strategies featured in constructivist grief therapy, which promotes a focus on meaning making activity as a basis for the empowerment of a meta-reflexive self (Neimeyer et al., 2010).

One important difference in this case, relative to other good outcome therapies, concerns the virtual nonexistence of protest IMs throughout the entire therapeutic work—something not observed in other therapies studied to date. Perhaps this difference is attributable to the therapy's focus on new ways of perceiving the loss, helping Cara create a symbolic connection with Spirit. Thus, change takes place by promoting new understandings of the problem and its effects, and through new strategies to cope with her mourning that enable new self-positions, rather than through a cathartic emphasis on the expression of anger about the traumatic loss. In this sense, contrary to the presence of protest IMs observed in other cases (e.g. depression, women victims of partner violence) where the client engaged in a position of criticism towards the problem's demands, criticism directed towards the loss could be a problematic position as the reality of death may be so incontrovertible that protest, per se, is futile. However, traditional grief theories posit that anger and protest are a common "stage" in grief work (Kubler-Ross, 1969), though one that is less commonly observed by contemporary researchers (Holland & Neimeyer, 2010). At other times protest IMs can involve the assertion of personal needs and rights when clients assert their interpersonal boundaries and stand up for themselves. In fact, in Cara's therapy, the only two times protest appears, it is addressed not the loss itself, but to her family expectations to support her pregnant stepdaughter. We thus suggest that, in keeping with a constructivist view of complicated grief, the main therapeutic goals consist in the acceptance and integration of the loss of the loved one, and in this sense both forms of protest IMs (criticism toward the problem and self-assertion) may lose much of their relevance. Furthermore, this absence of protest is compatible with a constructivist view that although adaptation to bereavement involves acceptance of the reality of loss, healing arises from the effort to make sense of one's changed live as a survivor.

Whether the low salience of protest is a unique feature of a meaning reconstruction approach, whether it typifies successful grief therapy more generally, or whether it reflects the somewhat stoic and practical approach of Cara herself can only be determined by the study of other cases and other relevant therapies for bereavement. This acknowledgement underscores the limitations of the present study. As a qualitative approach to the study of psychotherapy process, the IMCS has the advantage of yielding quantitative features in the unfolding of therapy that appear linked to positive outcomes (Gonçalves, Mendes et al., 2011; Matos et al., 2009;

Mendes et al., 2010). However, as an intensive analytic procedure that yields a fine-grained portrayal of the change process, it is difficult to apply to large numbers of cases in a single study, and by its nature it cannot give a causal account of therapy outcome. Likewise, it is an empirical question whether the patterns observed in this particular case study would generalize to other cases treated by the same therapist, or by others utilizing a similar approach to grief therapy with other adult clients. Even with these acknowledged constraints, however, we are hopeful that the reliable detection of innovative moments of change in the course of meaning reconstruction provides further demonstration of the relevance of the IMCS to the study of diverse therapies, greater evidence for the potential role of meaning reconstruction in grief therapy, and additional inspiration for future researchers to link these measurable moments of change to particular therapist and client activities that give rise to them. Ultimately, we believe that the close inspection of the course of therapy as actually practiced by skilled therapists will contribute to ongoing efforts to bridge the gap between science and practice in the field of grief therapy (Neimeyer, Harris, Winokeur & Thornton, 2011), and in the field of psychotherapy in general.

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CHAPTER II

AMBIVALENCE AND INNOVATIVE MOMENTS IN GRIEF PSYCHOTHERAPY: THE CASES OF EMILY AND ROSE

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AMBIVALENCE AND INNOVATIVE MOMENTS IN GRIEF PSYCHOTHERAPY: THE CASES OF EMILY AND ROSE[3]

1 ABSTRACT

Several studies have suggested that the process of narrative change in psychotherapy occurs through the emergence and expansion of moments of novelty, known as *innovative moments* (IMs), that allow changes in the problematic self-narrative responsible for the client's suffering. However, as these IMs challenge typical (and problematic) ways of acting, feeling and thinking, they may also generate discrepancy or uncertainty. Clients may reduce uncertainty by returning to the problematic self-narrative immediately after the emergence of an IM, thus ensuring the homeostasis of the previous meaning system. This cyclical movement is a form of ambivalence, which can maintain problematic stability across therapy and lead to therapeutic failure. In this study, we identified return to the problem markers (RPMs), which are empirical indicators of the ambivalence process, for all IMs in two cases of constructivist grief psychotherapy. Both cases evidenced a high percentage of IMs with RPMs, and the evolution of IMs and RPMs along treatment was significantly correlated. We suggest that stability of the ambivalence process in grief psychotherapy may represent a form of self-protection from the anxiety or guilt of investing in a less painful grief experience as a disconnection from the deceased.

2 INTRODUCTION

Recent research on bereavement has demonstrated that the incapability to make sense of and integrate loss into a new personal narrative is associated with complicated, protracted grief symptomatology (Coleman & Neimeyer, 2010; Currier, Holland, Coleman, & Neimeyer, 2007; Keesee, Currier, & Neimeyer, 2008;

[3] This study is in press in the Journal *Psychotherapy* with the following authors: D. Alves, P. Fernández-Navarro, A.P. Ribeiro, E. Ribeiro, & M. M. Gonçalves.

Lichtenthal, Currier, Neimeyer, & Keesee, 2010). Here, we present a proposed narrative framework of analysis that gives special relevance to the study of the narrative processes involved in self-reconstruction in constructivist grief psychotherapy.

2.1 Narrative Framework: Psychotherapy as meaning reconstruction

As poetically stated by Bruner (2002), "a self is probably the most impressive work of art we ever produce" (p.14). According to the narrative framework, humans shape their existence as active storytellers, recounting their experiences and personal stories to others, and being influenced by the contributions of others to this dialogue (Bruner, 1990; McAdams, 1993; Sarbin, 1986). These stories "not only govern which meanings are attributed to events, but also select which events are included and which are left out of the story'' (Polkinghorne, 2004, p. 58). As these specific interpretations can narrow people's understanding of themselves and the world around them, some self-narratives may become dysfunctional and inflexible (Dimaggio, 2006; Hermans & Kempen, 1993). As suggested by White and Epston (1990), maintenance of these dominant stories may confine all experiences into a problematic self-narrative, which becomes biased towards the negative details of the experience (Gonçalves & Machado, 1999). If we consider the experience of losing a significant person, narrative dominance may occur when the survivor's life becomes regulated by the "narrative of loss", privileging the most painful and threatening details of a changed reality (Currier & Neimeyer, 2006).

2.2 Narrative Reconstruction: Innovative Moments and Protonarratives

Several studies of psychotherapy have shown that the processes of narrative transformation occur through the emergence and expansion of alternative details of the problematic self-narrative, known as innovative moments (IMs) (Alves, Mendes, Gonçalves, Neimeyer, 2012; Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Matos, Santos, Gonçalves, & Martins, 2009; Mendes, Ribeiro, Angus, Greenberg, Sousa, & Gonçalves, 2010; Ribeiro & Gonçalves, 2011; Santos, Gonçalves, Matos, & Salvatore, 2009; Santos, Gonçalves, & Matos, 2010). Inspired by White and Epston's (1990) notion of "unique outcomes", innovative moments are experiences that are not predicted by the problematic self-narrative (Gonçalves,

Matos, & Santos, 2009). The Innovative Moments Coding System (IMCS; Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011) defines five types of IMs (action, reflection, protest, reconceptualization and performing change) that are exhibited by clients during therapeutic conversation. Examples of these IMs are presented in Table 1.

Table II. 1: The Innovative Moments Coding System (Gonçalves, Ribeiro et al., 2010)

Types of IM	Subtypes	Contents
Action IM (A) Actions or specific behaviors against the problem(s).		New coping behaviors facing anticipated or existent obstacles Effective resolution of unsolved problem(s) Active exploration of solutions Restoring autonomy and self-control Searching for information about the problem(s)
Reflection IM (R) Thinking processes that indicate the understanding of something new that makes the problem(s) illegitimate (e.g., thoughts, intentions, interrogations, doubts).	(i) Creating distance from the problem(s)	Comprehension – Reconsidering problem(s)' causes and/or awareness of its effects New problem(s) formulation Adaptive self instructions and thoughts Intention to fight problem(s)' demands, references of self-worth and/or feelings of well-being
	(ii) Centered on change	Therapeutic Process – Reflecting about the therapeutic process Change Process – Considering the process and strategies implemented to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change). New positions – references to new/emergent identity versions in the face of the problem(s).
Protest IM (P) Moments of critique that involve some type of confrontation (directed at others or versions of oneself); could be planned or actual behaviors, thoughts, or/and feelings.	(i) Criticizing the problem(s)	Position of critique in relation to the problem(s) and/or others who support it. The other could be an internalized other or facet of oneself.
	(ii) Emergence of new positions	Positions of assertiveness and empowerment Repositioning oneself towards the problem(s)

Reconceptualization IM (RC) Process description at a meta-cognitive level (the client not only manifests thoughts and behaviors out of the problem(s) dominated story but also understands the processes that are involved). If the RC includes Performing Change (PC) we should code RC with PC (RCPC)[4].		RC always involve two dimensions: A. Description of the shift between two positions (past and present) and B. The process underlying this transformation
Performing Change IM (PC) References to new aims, experiences, activities or projects, anticipated or in action, as consequence of change.		Generalization into the future and other life dimensions of good outcomes Problematic experience as a resource to new situations Investment in new projects as a result of the process of change Investment in new relationships as a result of the process of change Performance of change: new skills Re-emergence of neglected or forgotten self-versions

One of the main results of studies using IMCS is that poor and good outcome cases have different IM profiles. Initially, IMs appear in both poor outcome cases (PO) and good outcome cases (GO), although in GO cases their duration and diversity are higher and they tend to increase throughout the treatment. Additionally, in GO cases, action, reflection, and protest IMs tend to progress to reconceptualization and performing change in the middle and later parts of treatment, an uncommon movement in PO cases (Gonçalves et al., 2012; Matos et al., 2009; Mendes et al., 2010). Furthermore, as reconceptualization and performing change emerge, new action, reflection and protest IMs develop, allowing for the development of new sequences of reconceptualization and performing change IMs that consolidate the narrative change of the self (Gonçalves, Matos et al., 2009).

Different from the narrative flexibility proposed by the elaboration of IMs, problematic self-narratives promote the maintenance of implicit rules that shape clients' meaning system, influencing their behavior, thoughts, feelings and relationships. As an example, in a complicated grief case, the client may shape his or her life by the rule "I stopped living my life, it no longer makes sense because he/she is no longer here". This implicit rule has a wide influence on the client's existence, creating strong restraints on his or her life. From this perspective, IMs can be conceived as exceptions to the rule as they introduce novelty into a client's life,

[4] For the IMs salience analysis, RCPC was included in RC salience.

challenging the problematic self-narrative. For example, in a successful grief case of a mother who lost her unborn child, Alves and collaborators (2012) found that the emergence and expansion of IMs were associated with a gradual transformation of the problematic self-narrative (characterized by confusion, anger and disbelief) into a more healthful story of loss.

Another important feature of IM development is that they tend to cluster around different themes. For instance, in the example above there may be two different alternative, or innovative, themes: "Life goes on and nothing will bring back my lost one" and "I may try to find a new purpose to live, I don't need to give up without even trying". Moreover, different types of IMs, from action to performing change, may be present in each of these themes. We termed these alternative themes protonarratives, as they represent potential new, more adjusted, self-narratives. In summary, in the course of the treatment, IMs with several different meanings start to become organized into provisory themes, or protonarratives, which differ from the themes embedded in the problematic self-narrative (Ribeiro, Bento et al., 2011). Different protonarratives emerge along treatment, progressing into a new self-narrative throughout successful therapy.

2.3 Maintaining Problematic Self-Narratives: The Role of Ambivalence

Innovative Moments (IMs) can be understood as unfamiliar experiences that challenge a client's problematic, but usual, way of experiencing the world. This unfamiliarity of the experiences involved in IMs could thus generate uncertainty or ambivalence (Ribeiro & Gonçalves, 2010). As suggested by Hermans and Dimaggio, even though uncertainty "challenges our potential for innovation and creativity", it also "entails the risks of a defensive and monological closure of the self" (2007, p.10). Recent studies using the IMCS have shown that in both poor-outcome cases (Santos et al., 2010) and in the initial and middle phases of good-outcome cases (Ribeiro & Gonçalves, 2011), clients tended to attenuate the impact of IMs by returning to the problematic self-narrative. Gonçalves, Ribeiro, Stiles et al. (2011) proposed that the identification of these ''return to the problem markers'' (RPMs) could be an empirical access to the phenomenon of ambivalence in psychotherapy. These are instances in which an IM is attenuated by a return to the problematic self-narrative. The following is an example of this process: "I don't want to suffer

anymore [reflection IM] but I don't know how to do it" [return to the problem marker]. In this process, the client oscillates between the production of an IM, which liberates him or her from the oppression of problematic self-narratives, but as the innovation menaces his or her sense of self-stability, he or she quickly makes a return to the problematic self-narrative.

According to Gonçalves and collaborators (e.g., Ribeiro & Gonçalves, 2010; Gonçalves, Ribeiro, Stiles et al., 2011), the systematic recurrence of RPMs throughout the therapeutic process can inhibit the development or transformation of the self-narrative, fostering therapeutic failure. These claims were supported by one study of narrative therapy (Gonçalves, Ribeiro, Stiles et al., 2011) where it was found that RPMs occurred with significantly greater frequency in poor outcome cases compared to good outcome cases.

To the best of our knowledge, there is no research to date on the emergence of RPMs in the process of narrative change in grief psychotherapy. Studying this process might be particularly important because, as stated by Neimeyer (2006b), major losses can menace a person's efforts at self-coherence, stimulating an active redefinition of the previous self-narrative.

2.4 Grief Psychotherapy: The Meaning Reconstruction Activity

Although the majority of persons respond resiliently to loss (Bonanno, 2004), there is evidence that approximately 10 to 20% of the bereaved manifest serious difficulties in making sense of this experience (Bonnano, Wortman, & Nesse, 2004), and develop a complicated grief response (Prigerson et al., 1995; Prigerson & Maciejewski, 2006) or prolonged grief disorder (Boelen & Prigerson, 2007; Prigerson et al., 2009). Considering the incapacity to integrate loss as a significant predictor of grief severity, several authors have been suggesting the relevance of meaning making strategies with grieving individuals (Keesee et al., 2008; Lichtenthal et al., 2010; Neimeyer, Burke, Mackay, & van Dyke-Stringer, 2010). One recent randomized controlled trial showed, for example, the effectiveness of meaning making forms of journaling on prolonged grief and distress symptomatology (Lichtenthal & Cruess, 2010).

Along with the relevance of these meaning-centered interventions, this study explores how two constructivist grief clients transform – through the elaboration of

IMs – or maintain – through the recurrence of RPMs - their problematic self-narratives over the course of therapy. We also reflect on the implications of these processes on narrative change in complicated grief, exploring the themes or protonarratives through which this change occurred.

In general, this research aims to add relevant information to the existing knowledge of meaning making processes in grief therapy by analyzing narrative change in two complicated grief cases previously unexamined.

3 METHOD

3.1 Clients

3.1.1 Emily

Emily (pseudonym) was a 30-year-old Portuguese white female, babysitter and housemaid, who gave permission for her materials to be used for research. She attended 13 therapeutic sessions two years after the death of her 80-year-old grandmother who died after a stroke. She lived with her 3-year-old daughter in the same town as her close family; her husband was an emigrant worker in a foreign country. She described her physical proximity to her family and her role as a family caregiver as central features of her personality. Emily's problematic self-narrative pointed to a mixture of emotions ruled by intense pain and guilt, mostly for not having been able to give a goodbye kiss to her grandmother on the day of her funeral, imagining her grandmother as being sad and disappointed. In the initial phases of the process, Emily sustained a persistent centrality on physical contact and proximity with her loved ones as central aspects of the connection with her family, showing difficulty investing in the creation of a more representational and symbolic relationship with her grandmother. She had also difficulty in making sense of the concept of death as a persistent physical separation, feeling completely devastated by the idea of losing another significant person. In general, she described herself as a sad person who was unable to return to her previous work and social functioning, and felt isolated at home.

3.1.2 Rose

Rose (pseudonym) was a 58-year-old Portuguese woman who worked as a child educator and was retired at the time of therapy. She took part in therapy three years after the death of her 17-year-old son, from prostate cancer, and six months after the death of her husband, ran over by a car at his place of work. She lived in a small city with her 23-year-old daughter, located quite far from other family members. Rose's problematic self-narrative was ruled by an intense feeling that her life no longer made sense. When she started therapy, she described the "wish of having her son and husband in her life in a different way" as her main therapeutic goal. Before therapy, she was already involved in the search for a symbolic and less painful connection with them through the reading of grief books and attendance at a self-help group for bereaved parents. However, these attempts did not have the results she expected ("being more comforted") and she felt that her life was empty and meaningless. Along with these feelings, she reported intense guilt related to several choices she made in the past (e.g., to provide cancer treatments to her son only in Portugal or insisting that her husband kept working at the place where he ended up dying, despite his dissatisfaction with that job). Thus, she felt that she did not deserve the right to go out and enjoy herself as her son and husband were deprived of that right. This problematic self-narrative ended up impairing her personal and social functioning, resulting in her being isolated at home. Additionally, she reported intense discomfort dealing with family meetings, feeling that the core part of her family had been taken from her.

3.2 Therapist and Therapy

Both clients attended psychotherapy at a Portuguese university clinic, where they were seen weekly in individual therapy sessions. They were treated by the same female therapist, a 25-year-old clinical psychology doctoral student with three years of prior clinical experience as psychotherapist and two years of experience in constructivist grief psychotherapy. A skilled therapist with 18 years of clinical experience as a constructivist psychotherapist supervised the clinical practice to ensure adherence to the constructivist therapeutic model. Video and audio recordings were made of all sessions in both cases.

The therapy was developed from the constructivist meaning reconstruction

approach proposed by Neimeyer (2001; 2006a) and involved an initial exploration of the client's story of loss, oriented by the "Meaning Reconstruction Interview" (Neimeyer, 2006a, pp.166-169). This first contact, guided by an empathic validation and exploration of the most painful aspects of the grieving experience, allowed for the identification of the multiple challenges and resources of each client. Although this constructivist approach does not have a specific or manualized structure, it has the central objective of helping clients to find a new understanding and healthful significance of their losses by co-construction of new meanings that potentiate self-development (Neimeyer et al., 2010).

In Emily's case, the main therapeutic activities were "narrative retelling" (Neimeyer et al., 2010, p.76) and "imaginal conversations" (Shear, Boelen, & Neimeyer, 2011, p.149) with the deceased. By proposing Emily's involvement in these meaning oriented activities, the therapist (grounded in constructivist grief therapy) actively invested in the co-construction of new and less anguished elaborations of the most painful episodes of her grief (Neimeyer et al., 2010), being consistent with the assumptions postulated by the constructivist grief therapy (Neimeyer, 2006a). These therapeutic activities were also organized in order to stimulate the construction of a more symbolic post-mortem connection (Field, 2006; Shear et al., 2011) associated with less grief distress (Field, Nichols, Holen, & Horowitz, 1999).

In Rose's case, "imaginal conversations" (Shear et al., 2011, p.149) and "therapeutic writing" (Neimeyer et al., 2010, p.78) were the main activities. Being also consistent with the meaning making approach proposed by the constructivist grief therapeutic model (Neimeyer, 2006a), the therapist created an opening space for discussion and dialogue in order to allow the client to elaborate on a more compassionate viewpoint of her lost loved ones, thus promoting a new perspective around the most anguishing episodes of her experience of loss (Neimeyer et al., 2010).

This study is part of a process research study approved by the ethical committee of the local hospital (the institution that referred cases for treatment), in which clients were offered 15 sessions of therapy over 22 weeks. Emily completed 13 sessions, at which time the therapeutic aims were achieved and no more therapy was required. Rose was referred for further treatment, given the continued presence of complicated grief symptomatology at the end of the clinical trial.

3.3 Researchers

Two judges conducted the Innovative Moments (IMs), the Return to the Problem (RPM) and protonarrative analysis of all the sessions of both cases. Both judges were doctoral students in clinical psychology. A third researcher, also a doctoral student in clinical psychology, served as an auditor of the RPM and protonarrative coding as he was experienced with these procedures. Judge 2 and the external auditor were unaware of clients' clinical outcomes in all the instruments applied.

3.4 Measures

3.4.1 Outcome Measures

Structured Clinical Interviews for the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR; American Psychological Association, 2000), *Axis I* (SCID-I; First, Spitzer, Gibbons, & Williams, 2002) and *Axis II* (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). SCID-I and SCID-II are structured clinical interviews grounded on the DSM-IV-TR diagnostic criteria that allow for the assessment of a client's disorders on axis I (mood, psychotic and anxiety disorders) and axis II (personality disorders). Inter-rater reliability ranged from .83 to .85 in SCID-I (Del-Ben et al., 2001) and was .63 in SCID-II (Weertman, Arntz, Dreessen, Velzen, & Vertommen, 2003).

Inventory of Complicated Grief (ICG; Prigerson et al., 1995). The ICG is a 19-item questionnaire that assesses the severity of grief symptoms in the previous month. The items are rated on a 5-point Likert scale, from 0 to 4, with total possible scores ranging from 0 to 76. A total score of above 25 suggests complicated grief. The scale shows good internal consistency (.94; Prigerson et al., 1995). We used the Portuguese adaptation by Frade, Pacheco, Sousa, and Rocha (2009), which also presents good internal consistency (.91; Frade et al., 2009). The cut-off score for the Portuguese population was 30 (Sousa & Rocha, 2011).

Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996). The BDI-II is a 21-item questionnaire that assesses depressive symptoms. The items are rated on a 4-point Likert scale, from 0 to 3, with total scores ranging from 0 to 63. The scale shows high internal consistency (.91; Steer, Brown, Beck, & Sanderson,

2001). In this study we used the Portuguese adaptation by Coelho, Martins, and Barros (2002), with a cutoff of 14.29 and a Reliable Change Index (RCI, Jacobson & Truax, 1991) of 8.46, as proposed by Seggar, Lambert, and Hansen (2002).

Outcome Questionnaire (OQ-45.2; Lambert et al., 1996). The OQ-45.2 is a 45-item questionnaire that assesses a client's clinical progress throughout the therapeutic process. It evaluates the client's progress in three dimensions: subjective discomfort, interpersonal relationships and social role functioning. The items are rated on a 5-point Likert scale, from 0 to 4, with total scores ranging from 0 to 180. This questionnaire has good test-retest reliability (.84) and high internal consistency (.93; Lambert et al., 1996). We used the Portuguese version by Machado and Klein (2006) that has good internal consistency (Machado & Fassnacht 2012). The Reliable Change Index (RCI; Jacobson & Truax, 1991) is 18 points and the cut-off score is 62.

3.4.2 Process measures

Innovative Moments Coding System (IMCS; Gonçalves, Ribeiro, et al., 2010; Gonçalves, Ribeiro, Mendes, et al., 2011). The IMCS is a system of qualitative analysis that identifies 5 categories of Innovative Moments (IMs): action, reflection, protest, reconceptualization and performing change (see each IM description in Table 1). Previous studies using the IMCS (Gonçalves, Mendes et al., 2012; Matos et al., 2009; Mendes et al., 2010) reported reliable agreement between judges in coding, with Cohen's kappa between .86 and .97.

Return to the Problem Coding System (RPCS; Gonçalves, Ribeiro, Santos, J. Gonçalves, & Conde, 2009). The RPCS is a qualitative system that analyzes the re-emergence of the problematic self-narrative through the elaboration of RPMs immediately after the emergence of an IM. Previous studies using the RPCS (Gonçalves, Ribeiro, Stiles et al., 2011; Ribeiro, Cruz, et al., 2012; Ribeiro, Mendes, et al., 2012) reported a reliable agreement between judges on RPM coding, with a Cohen's kappa between .88 and .93.

Protonarratives Coding System (PCS, Ribeiro, Gonçalves, & Bento, 2010). The PCS analyzes the underlying theme of each IM, known as a protonarrative. The themes or protonarratives are identified from a consensus between coders, after the reading of all IMs from all the sessions. Thus far, PCS has been applied to Emotion-Focused Therapy (Bento, Ribeiro, Salgado, Gonçalves, Mendes, 2012),

Constructivist Therapy (Ribeiro, Bento et al., 2011) and Cognitive-Behavioral Therapy (Antunes, Santos, Ribeiro, & Gonçalves, 2012), in different cases (e.g., major depression, survivors of partner violence).

3.5 Procedure

3.5.1 Outcome measures

The SCID-I (First et al., 2002) and SCID-II (First et al., 1997) were administered during the first meeting with both clients to assess co-morbidity with other disorders that could be clinically more central than complicated grief. Concomitantly, in the first session, the Portuguese version of the ICG (Frade et al., 2009) was administered to screen for complicated grief symptoms. The ICG was then administered every fourth session and at 6-month follow-up. The BDI-II was also used in every fourth session and at follow-up, as depressive symptomatology has been identified as being related to grief distress (Bonanno & Mancini, 2006). The same procedure was used for administration of the OQ-45.2 for screening of the client's psychological progress throughout therapy.

Emily was diagnosed with complicated grief, comorbid with major depression, as defined by the DSM-IV (American Psychiatric Association, 1994). She showed a significant clinical change at the end of therapy, according to the RCI analysis (see Jacobson & Truax, 1991) of her pre to post-test scores on the ICG (from 42 to 11, cut-off score 30), the BDI-II (from 26 to 8, cut-off score 14.29) and the OQ-45.2 (from 73 to 38, cut off-score 62). In the last follow-up session, 6 months after treatment termination, she scored 4 on the ICG, 8 on the BDI-II and 32 on the OQ-45.

Rose was also diagnosed with complicated grief, comorbid with major depression. She showed a considerable pre-post score reduction in the BDI-II (from 35 to 15, cut-off score 14.29) and in the OQ-45.2 (from 91 to 64, cut-off score 62), maintaining the same scores until the last follow up session. However, she maintained a clinical score on the ICG at sessions 15 and follow-up (scores of 42 and 41, respectively, beginning with score of 55 at session 1, cut-off score 30). Thus, her depressive symptoms (assessed by the BDI-II) and her psychological functioning (assessed by the OQ-45.2) improved, but her grief symptomatology (assessed by the ICG) did not improve.

Despite research evidence suggesting comorbidity between complicated grief and Posttraumatic Stress Disorder (PTSD; McDevitt-Murphy, Neimeyer, Burke, & Williams, in press), neither Emily nor Rose met the criteria for a PTSD diagnosis.

3.5.2 Process measures

Innovative Moments Coding System (IMCS): IMs training, coding and reliability

The transcripts of all the sessions of both cases were independently coded by judges 1 and 2, using the IMCS (Gonçalves, Ribeiro, Mendes et al., 2011). As only judge 1 had previous experience using the IMCS, judge 2 completed a training procedure before initiating coding of these cases. A skilled external auditor supervised the training process. By the end of the training process judge 2 was considered a reliable coder, with a Cohen's kappa higher than .75.

Judges discussed their understanding of the client's problems before the coding process to generate a consensual definition of the aspects of the problematic self-narrative, so that exceptions (IMs) could be coded. Subsequently, each session was independently coded in terms of types and salience of IMs. The salience index indicates the percentage of text in the session occupied by a specific IM and is computed by calculating the number of words involved in each type of IM divided by the total number of words in the transcript of the session. Sessions were coded sequentially, considering both therapist and client contributions, as we believe that the process of change is co-constructed (Neimeyer, 2009).

The percentage of salience agreement between judges was 84.2% for Emily's case and 89.1% for Rose's case, reflecting a high degree of consensus regarding the number of words coded as IMs, across sessions. The agreement between judges for the specific types of IM, assessed with Cohen's kappa, was .96 for Emily's case and .91 for Rose's case, again indicating strong agreement among coders (Hill & Lambert, 2004).

Return to the Problem Coding System (RPCS): RPMs training, coding and reliability

Judges 1 and 2 participated in the RPM coding procedure. Judge 1 had experience with coding RMPs. Judge 2 underwent a training process similar to that described for IMCS training.

RPMs coding comprised two sequential steps: a) independent coding, and b) resolving disagreements through consensus. The judges independently coded the transcripts of all sessions of both cases, analyzing the previously coded IMs for the presence or absence of RPMs. Reliability of identifying RPMs, assessed by Cohen's kappa, was .80 for Emily's case and .79 for Rose's case. An external auditor also participated in the final RPM coding procedure, reviewing the decisions on RPMs coding made by judges 1 and 2.

Protonarrative Coding System (PCS): protonarratives coding procedures and reliability

Coding protonarratives involved consensual coding between judges 1 and 2, along with an auditing process (Hill et al., 2005) led by the same external auditor involved in RPMs coding. This phase was oriented by the question: "If this IM develops into a new self-narrative, what would be the main rule of this new self-version?" (Ribeiro, Bento et al., 2011). In both cases, we attempted to find the main theme or rule associated with the development of IMs, aggregating these themes into a sentence or word that designated the central protonarrative. Each successive IM was then compared with the identified protonarratives, looking for convergence or discrepancy. During this process, protonarratives were frequently reformulated to create a robust category capable of integrating the diversity of the new meanings. This procedure was based on grounded theory analysis (Fassinger, 2005). Each protonarrative's salience was calculated as the sum of the salience of the IMs in which they emerged, for each session. The mean salience of all protonarratives throughout the process was computed. Finally, the global percentage of IMs with RPMs was calculated separately for each protonarrative.

4 RESULTS

4.1 Innovative Moments (IMs) and Return to the Problem Markers (RPMs) across therapy

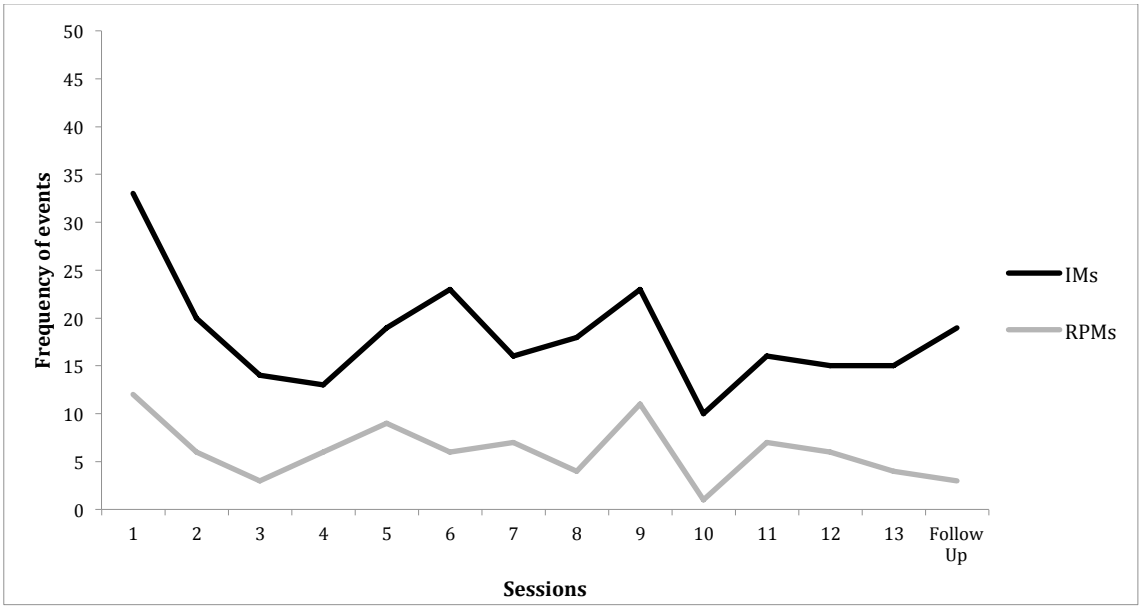
Emily's overall salience of IMs throughout the therapeutic process was 30.0%, with reflection and reconceptualization being the most salient IMs (15.2% and 8.5%, respectively). In Rose's case, IMs occupied 25.8% of the entire therapeutic

conversation, with reflection also being the most salient IM (22.9%). The main difference in IM patterns between Emily and Rose was in reconceptualization, which appeared as the second most salient IM in the final phases of Emily's therapeutic process (8.5%), but was infrequent in Rose's case (0.7%). Action, protest and performing change IMs presented low saliences in both cases (6.3% in Emily's case and 2.2% in Rose's case).

The total percentage of RPMs was 33.5% in Emily's case and 41.7% in Rose's case. In previous studies (Ribeiro, Cruz, et al., 2012; Ribeiro, Mendes, et al., 2012), the percentage of RPMs was between 20% and 40%. Reflection, the most salient IM in both cases, was also the IM with the highest percentage of RPMs, representing 89.4% of total RPMs in Emily's case and 87.7% in Rose's case.

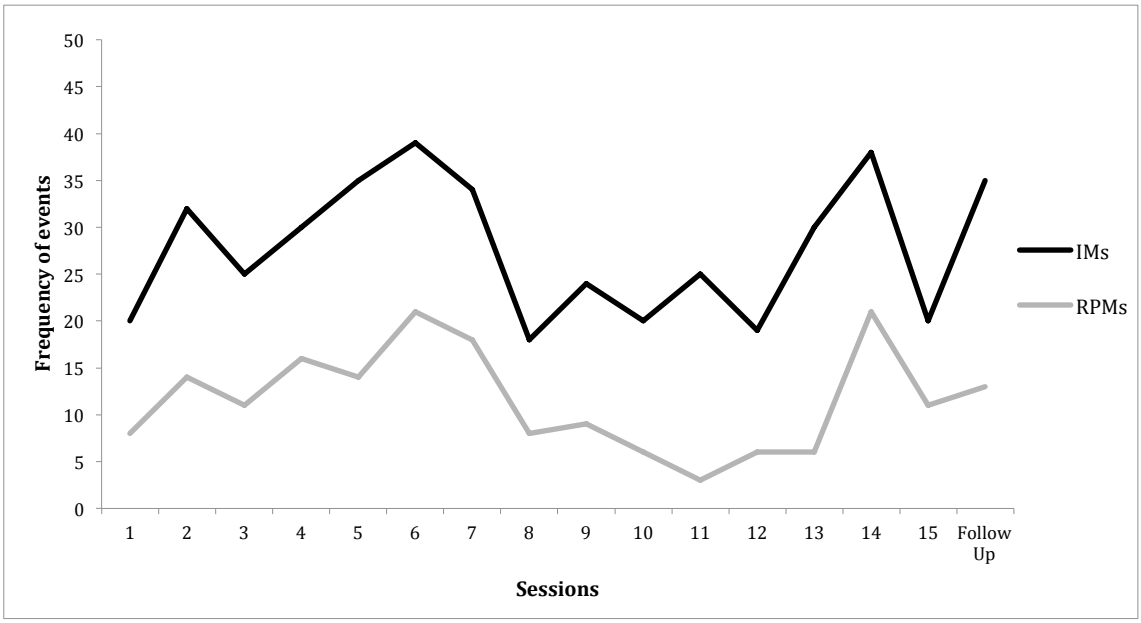
In both cases, the frequency of RPMs was significantly associated with the frequency of IMs. A time-series analysis using Simulation Modeling Analysis (SMA; Borckardt et al., 2008), a method for assessing the statistical significance of sequential observations in data series, indicated a cross-correlation at lag 0 between IMs and RPMs of .75 (p = .001) in Emily's case and .79 (p = .001) in Rose's case (Bonferroni correction was used). Despite the high correlation between IMs and RPMs, the cases showed distinct trajectories of RPMs from the middle stages of therapy to termination. In Emily's case, as presented in Figure 1, the frequency of RPMs progressively decreased from session 11 to the final session, and this decrease persisted 6 months later at follow up. The frequency of IMs, in turn, followed the opposite movement, increasing from the last session to follow-up.

Figure II. 1: Frequency of IMs and RPMs in Emily's case



In Rose's case, as shown below in Figure 2, the frequency of IMs and RPMs was associated during all the therapeutic process (which is specially noticeable in sessions 2, 6, 8 and 14). Regarding specifically the frequency of RPMs at the end of therapy, it decreased in session 15 but increased again in the follow-up session. The frequency of IMs followed the same pattern of evolution.

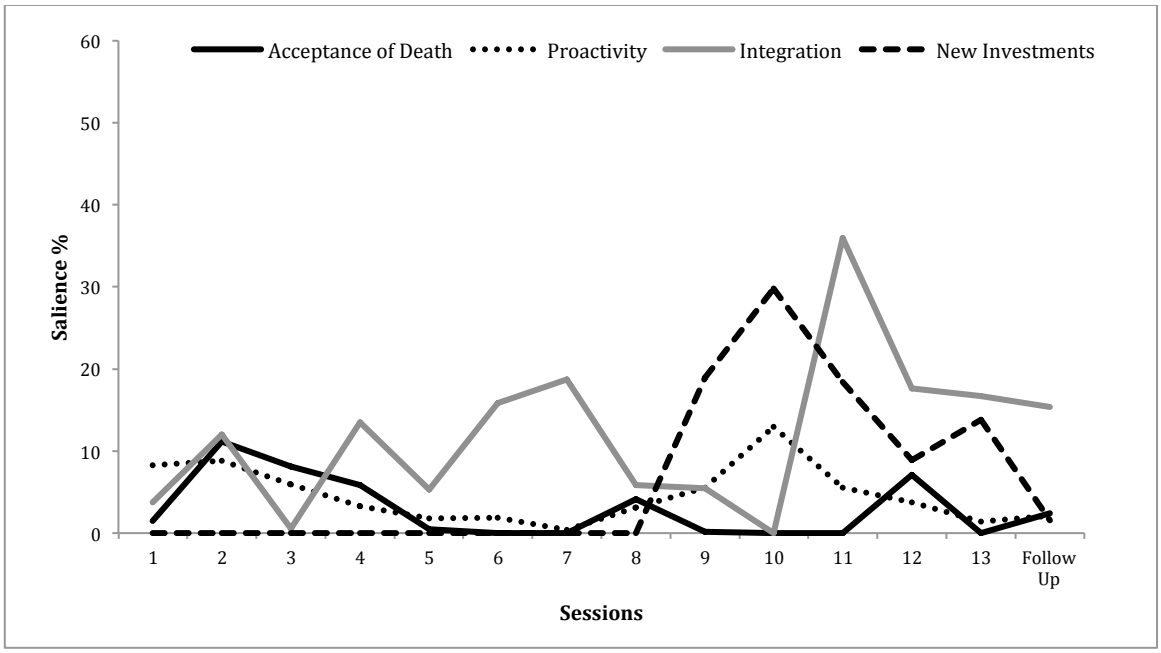
Figure II. 2: Frequency of IMs and RPMs in Rose's case



4.2 Protonarratives across therapy

In Emily's case, we identified 4 protonarratives, listed here according to the order in which they appeared in therapy: "Acceptance of Death" (Mean salience = 11.2%), "Proactivity" (Mean salience = 17.8%), "Integration" (Mean salience = 45.8%) and "New Investments" (Mean salience = 25.2%). "Acceptance of Death" consisted of IMs in which Emily positioned herself towards a more flexible understanding of death, considering, for example, the ways death could be beneficial to ill persons as a relief from pain, thus reformulating her grandmother's death as a release from pain. "Proactivity" designated Emily's proactive search for reorganization in her life, such as focusing on the daily experiences that genuinely gave her pleasure (e.g., cultivating flowers), strength and capacity to work (in opposition to her self-image as an immobilized, depressed and fragile person) and her positive relationship with her daughter, including the way in which their relationship motivated her to move forward in life. "Integration" was associated with Emily's elaboration on the construction of a healthier relationship with her grandmother, through a more symbolic, rather than physical, connection (Field, 2006; Field, Gao, & Paderna, 2005). This elaboration prompted a less painful experience of loss, and Emily gradually relinquished guilt for not having kissed her grandmother on the day of her funeral. Thus, she started to contemplate a more compassionate position toward herself regarding her grandmother, expressed through an unsent letter addressing this event. Consequently, as the therapeutic process evolved, she became more comforted by positive memories of her grandmother in her life (e.g., remembering her grandmothers culinary instructions each time she sees the cooking utensils her grandmother gave her). Finally, "New Investments" was associated with Emily's new projects as a consequence of her change (e.g., obtaining a drivers license, working at a coffee shop). The evolution of Emily's protonarratives throughout therapy is presented in Figure 3.

Figure II. 3: Salience of protonarratives in Emily's case

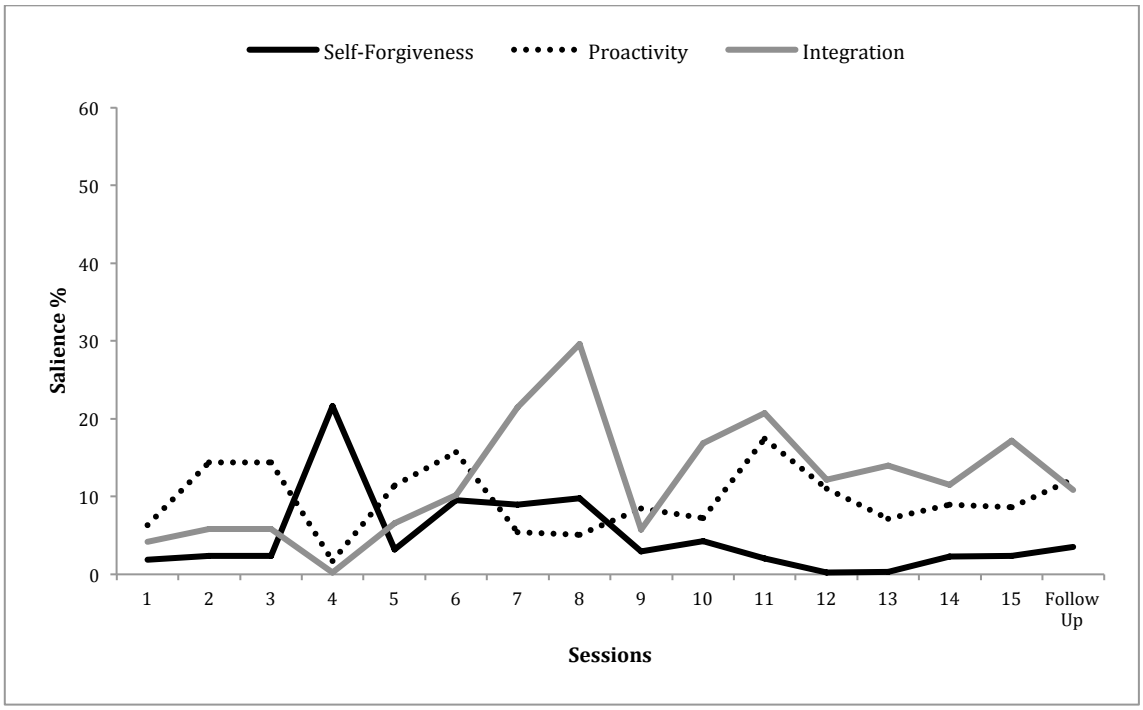


In the first phase of her treatment, "Proactivity" and "Acceptance of Death" were the most salient and stable protonarratives, and they decreased in salience as the middle phase of the therapy was reached. "Integration" emerged for the first time in session 2, and became the most salient protonarrative in the middle phase of therapy. In the final phase, "Integration" and "New Investments" were the most salient protonarratives.

In Rose's case, we identified 3 protonarratives: "Self-Forgiveness" (Mean salience = 18.2%), "Proactivity" (Mean salience = 36.5%) and "Integration" (Mean salience = 45.3%). "Self-Forgiveness" consisted of IMs associated with Rose's higher tolerance regarding the decisions she made in the past involving her son and husband. Specifically, through a metaphor of a "court trial", Rose (the judge) considered alternative "verdicts" to her life by imagining the voices of her lost loved ones (or others relatives and friends) as "voices of defense against guilt", organizing a scenario where the guilt's voice was not the only one to be heard. This scenario is illustrated in the following excerpt of a letter she wrote from the perspective of her son: "*Mother, you did everything you could for me, you were with me at the hospital, you left your work (...) now you need to move on and also think about my sister*". "Proactivity" incorporated Rose's experiences of well being, resulting from her proactive search for life reorganization (e.g., computer classes, yoga). This theme

also incorporated her intentions to fight for the happiness of her daughter, which motivated her to move forward in life. Finally, "Integration" incorporated Rose's investment in the construction of more adaptive, less painful relationships with her son and husband (e.g., *"I want to have them in my life in a different way, it's very difficult to sustain this pain everyday*"). Through exploration of the "court trial" metaphor in "Self-Forgiveness", Rose gradually became more tolerant of herself, allowing the emergence of healthier memories of her lost ones, not only memories ruled by an intense pain. Therefore, from the middle to the final phases of therapy, "Integration" began to incorporate not only her attempts to process her grief in a more adaptive way but also the effects of these efforts, as she started to notice a more peaceful presence of them in her life (e.g., "*Sometimes when some of my friends invite me to participate in activities such as walking in the city, I almost feel like they* (her son and husband) *are saying to me 'go, it's good for you, don't be so sad, we are fine' "*). The evolution of Rose's protonarratives throughout therapy is presented in Figure 4.

Figure II. 4: Salience of protonarratives in Rose's case



In general, "Proactivity" and "Self-Forgiveness" were the most salient themes in the initial phase of the process. From the middle phase to the final phase,

"Integration" and "Proactivity" became the most salient protonarratives.

4.3 Protonarratives and RPMs across Therapy

Table 2 presents a cross-correlation analysis at lag 0 between the frequency of IMs of each protonarrative and the total frequency of RPMs of each case. It was conducted with the *Simulation Modeling Analysis* (Borckardt et al., 2008; with a Bonferroni correction for multiple comparisons).

Table II. 2: Mean salience of protonarratives throughout the process and cross-correlation analysis at lag 0 between the IMs of each protonarrative and the total frequency of RPMs in both cases (*p <. 05; **p <. 01)

Clients	Protonarratives	Protonarratives Salience	Cross-correlation protonarrative IMs x RPMs; Bonferroni correction for multiple comparisons
Emily	Integration	45.8%	r = .51; p = .02*
	New Investments	25.2%	r = .13; p = .31
	Proactivity	17.8%	r = .28; p = .14
	Acceptance of Death	11.2%	r = .19; p = .24
Rose	Integration	45.3%	r = .08; p = .39
	Proactivity	36.5%	r = .64; p = .004**
	Self-Forgiveness	18.2%	r = .62; p = .007**

In Emily's case, the only protonarrative in which the IMs were significantly correlated with RPMs was "Integration", which was also the most salient protonarrative of the entire case. In Rose's case, IMs from both "Proactivity" and "Self-Forgiveness" were significantly correlated with RPMs. In "Integration", the most salient protonarrative of Rose's case, IMs were not significantly correlated with RPMs.

In the following section we further describe and analyze the protonarratives in which RPMs and IMs were more correlated, given that these were the protonarratives in which ambivalence was stronger.

4.4 Descriptive analysis of the association between protonarratives and RPMs

In Emily's case, "Integration" emerged during the first session and was the

most salient theme across therapy. Additionally, it was the theme most associated with the emergence of RPMs. As presented above, its contents were associated with Emily's investments in a more symbolic relationship with her grandmother, one that was less ruled by pain and guilt. For example, in session 7, after the therapist's suggestion to reopen dialogue with her grandmother and to share with her the guilt Emily had felt since her funeral, by not having kissed her lifeless body, Emily began reassessing the experience in a more flexible way: "*Maybe I was protecting myself, and also my brother took me away from the church, it was not only my decision*". She continued this elaboration in session 8, using a visualization of a more tolerant position of her grandmother, as shown in the following excerpt: *"I think that she would accept my apologies ... she would consider that it is necessary to have a lot of courage to do it. Maybe she… in fact she didn't go to my uncle's funeral* (her son), *probably she also didn't have the courage to do it"*. Nevertheless, Emily's elaboration of "Integration" was frequently interrupted with RPMs, through which she mainly reasserted the guilt of not having kissed her grandmother on the day of her funeral. This movement reinforced the distress of physical separation, attenuating her investment in a more representational or symbolic bond with her grandmother. To illustrate this point, let us consider the following example from session 8, in which she reflected on the way she felt regarding the activity of reopening dialogue with her grandmother: *"It was a relief to have been able to say it to her, asking her forgiveness* [emergence of an IM {Integration}] *but… it's not the same thing ... I should have given her a kiss. It's not that she could felt it, but I think it would have been important for her to have taken it"* [RPM— {Guilt}—IM's attenuation]. The attenuation of IMs through RPMs was recurrent in "Integration", especially in the initial and middle phases of the therapeutic process.

In Rose's case, "Proactivity" was significantly correlated with the emergence of RPMs. Attenuation of "Proactivity" was mainly associated with Rose's reiteration of her lack of right to move forward in life, reaffirming the recurrent, problematic self-narrative ruled by helplessness and guilt. It is illustrated in the following excerpt from session 6, in which Rose describes the way she felt when she took a ride with her daughter to the nearby city:

> *Client (C): Ah, I was hesitant, 'should I go or not?' Well, I end up convincing me to go, I felt some kind of strength or something saying, 'go, it will be good for you'*

Therapist (T): What was the meaning of that strength for you?

C: Well, it's like feeling that I shouldn't hold on to negative feelings but trying other things, other moments that offer me a kind of a way out [emergence of an IM {Proactivity}]. *Well, it's not that everything was fine because the guilt was always present* [RPM—{Helplessness and Guilt}—IM's attenuation].

"Self-Forgiveness" was also significantly correlated with the emergence of RPMs, through the reiteration of guilt, along with a feeling of incompetence regarding the decisions she took in the past involving her son and husband, as illustrated in the following excerpt from session 8 regarding seeking treatment for her son's cancer only in Portugal:

C: There are moments when I can hear a voice saying, 'you couldn't do anything more' or 'you did everything you could, the doctors said that the medical protocol used here (in Portugal) *was the same from other countries so you did the right thing'.*

T: Uh-huh.

C: sometimes I can hear these voices, you know?

T: the defense voices…

C: yes, saying, 'what more could you have done?' [emergence of an IM {Self-Forgiveness}] *but then there comes the other voice (guilt) up to me saying 'maybe I could have done more and I didn't, maybe the treatment in other countries, like in the U.S., could have saved him'* [RPM—{Guilt}—IM's attenuation].

5 DISCUSSION

A growing number of psychotherapy studies using the Innovative Moments Coding System (IMCS) and the Return to the Problem Coding System (RPCS) direct our attention to the role of Innovative Moments (IMs) in the transformation of problematic self-narratives (Alves et al., 2012; Gonçalves, Mendes et al., 2010; Matos et al., 2009; Mendes et al., 2010; Santos et al., 2009), and to the role of the Return to the Problem Markers (RPMs) in the maintenance of problematic self-narratives (Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro, Cruz, et al., 2012; Ribeiro, Mendes, et al., 2012). This study explores the transformation (IMs) and

maintenance (RPMs) of problematic self-narratives in two cases of constructivist grief psychotherapy, analyzing the main themes (protonarratives) involved in this change process.

The results show that the overall salience of IMs is slightly higher in Emily's case (30.0%) than in Rose's case (25.8%). In both cases, reflection is the most salient IM, with a total percentage of 15.2% in Emily's case and 22.9% in Rose's case. The main difference in the pattern of IMs between the 2 cases is in reconceptualization, which is the second most salient IM in Emily's case (8.5%), being infrequent in Rose's case (0.7%). The total percentage of RPMs, in turn, is slightly higher in Rose's case (41.7%) than in Emily's case (33.5%). A SMA analysis (Borckardt et al., 2008) shows that the progression of IMs and RPMs is significantly correlated at lag 0 in both cases, rising to .75 (p = .001) in Emily's case and .79 (p = .001) in Rose's case. These cross-correlations are higher when compared to a previous study examining IMs and RPMs in a sample of Emotion Focused Therapy of Depression (Ribeiro, Mendes, et al., 2012), in which the cross-correlation at lag 0 was .39 (p = <.001).

Despite the significant association between IMs and RPMs in both cases, there is a distinct evolution of RPMs at the end of therapy. While in Emily's case the frequency of RPMs shows a progressive decrease from session 11 to follow-up, there is an increasing and irregular movement of RPMs at the end of Rose's therapy. This is congruent with previous studies using the RPCS in Emotion Focused Therapy and Client-Centered Therapy, in which the evolution of RPMs tends to decrease in good outcome cases, and increases or remains stable and high in poor outcome cases (Ribeiro, Cruz, et al., 2012; Ribeiro, Mendes, et al., 2012). In both cases, "Integration" is the protonarrative that induces greater emergence of IMs. Thus, approximately 45% of the time when an IM is elaborated, it is related to the construction of a healthier and less painful relationship with a lost one. Curiously, the IMs of "Integration" are significantly correlated with RPMs in Emily's case (the case with the significant clinical change) and are not significantly correlated in Rose's case (the case without significant clinical changes in grief symptomatology). In fact, "Integration" is the only theme of Rose's case in which the IMs are not significantly correlated with the emergence of RPMs. We speculate that this result may be associated with the distinct ways through which the clients elaborated this protonarrative from the beginning of therapy. This protonarrative is associated with

the clients' reconstruction of a more symbolic connection with their lost ones, becoming also capable of finding a new comfort beyond physical contact (Field et al., 2005). When Emily began therapy, she described herself as a fragile person who could not accept the idea of human death and physical vanishing. During the first and middle phases of therapy, she described herself as being quite confused regarding the way she could accept the loss of her grandmother in a more symbolic way. Accordingly with this confusion, she recurrently attenuated "Integration" by validating the way she felt guilty for not having reached her grandmother physically (with a kiss) on the day of her funeral. However, it is interesting to note that during the final phase of the therapy, Emily begins to elaborate "Integration" though a meta-reflexive position (through the use of reconceptualization IMs; Cunha, Gonçalves, Valsiner, Mendes, & Ribeiro, 2012), by describing the way she created a new concept of human death (as a release from illness) and how it helped her accept her grandmother's death. Congruent with this innovative understanding of her change process, she starts reassessing her grandmother's existence through positive memories (e.g., cooking objects). This change suggests that, at this point, Emily was able to find positive comfort through a more symbolic representation of her grandmother. This achievement seems to be consistent with the assumptions proposed by Gonçalves, Matos et al. (2009) and Gonçalves and Ribeiro (2012) regarding the emergence of reconceptualization IMs in therapy. According to these authors, its emergence is associated with clients' reintegration of painful experiences into a new self-narrative, as they begin to see themselves as the principal authors of their change process. It is also interesting to note that the frequency of RPMs tends to decrease in the final phase of Emily's therapy. We speculate that, despite the significant correlation between IMs of "Integration" and RPMs, the emergence of reconceptualization may have stimulated a more flexible perception of Emily's ability to change, fostering a decrease in ambivalence, which is congruent with findings from previous studies (Cunha, Gonçalves, & Valsiner, 2011; Gonçalves, Ribeiro, Stiles, et al., 2011). It is also congruent with previous bereavement studies indicating the capacity to make sense of and integrate loss as a strong predictor of successful grief adaptation (Holland, Currier, & Neimeyer, 2006; Holland & Neimeyer, 2010; Keesee et al., 2008), as the client progressively transforms the prior relationship with the deceased into a more symbolic and comfortable connection (Neimeyer, 2006a).

In Rose's case, in contrast, IMs from "Integration" are not significantly correlated with the emergence of RPMs and did not consistently progress to an elaboration of reconceptualization. This theme seems to be consistent with the way Rose describes the objective that brings her to therapy: to have her son and husband in her life in a different way. Her search for a symbolic connection with her son and husband seems to have begun prior to therapy, as in the first session she described the way she obtained some comfort from reading grief books and participating in self-help groups for bereaved parents. Perhaps the consistency of "Integration" with her prior attempts to maintain bonds with her son and husband may help us understand why she tends to elaborate this theme with lower levels of ambivalence, feeling less compelled to protect herself from the anxiety of change (Engle & Holiman, 2002; Frankel & Levitt, 2009). As "Integration" focuses on her investment in her loved ones, she sees herself struggling for their presence in her life. In contrast, "Self-Forgiveness" and "Proactivity" (themes highly correlated with RPMs) incorporate the investment of new life goals and priorities – beyond the physical presence of her son and husband – through the release of the severe pain and guilt. Perhaps this discontinuity with her previous story of loss may be felt as an abandonment of her loved ones, as she may understand her intense pain as part of the terms of forming a new attachment to them (Rando, 2012). In this sense, in the majority of times in which she elaborated "Self-Forgiveness" and "Proactivity", she immediately felt compelled to reaffirm the way she was suffering by having lost them, protecting herself from the guilt of giving them up. This ambivalence seems to be in line with the assumptions postulated by Rando (2012), indicating that investment in life reorganization with lower levels of pain can be very difficult for some grief clients, manifesting as a type of resistance in therapy. Finally, even though in Rose's case "Integration" is not significantly correlated with the emergence of RPMs, this condition alone (elaboration of a theme with lower levels of ambivalence) is not sufficient for the creation of an alternative self-narrative. Therefore, although in the final phases of Rose's process "Integration" incorporates real episodes of a more peaceful presence of her loved ones in her life, the absence of reconceptualization indicates a fragile sense of authorship regarding the way this transformation process occurred. Given that, we hypothesize that until the emergence of a meta-perspective elaboration on the change processes (through reconceptualization IMs), the absence of ambivalence may indicate that the theme does not sufficiently disturb the client's

previous meaning system, and does not necessarily evolve into an innovative meaning reconstruction. This validates, again, the centrality of reconceptualization on the construction of a more stable and coherent alternative self-narrative (Cunha et al., 2011; Gonçalves, Matos et al., 2009). In conclusion, the marked absence of reconceptualization in all the themes that emerge in Rose's therapy may suggest that over the 15 sessions she did not form a stable integration of the most painful aspects of her experience into a more flexible self-narrative. Considering the fact that "Integration" (the most prevalent theme of the entire process) focuses on bond maintenance with her lost ones, these results direct our attention to the way this investment may facilitate or inhibit the bereavement adaptation. In fact, several studies have shown that when the survivor is unable to integrate loss in a more comforted way, the postmortem connection with the deceased may instigate higher levels of distress (Neimeyer, Baldwin, & Gillies, 2006).

Finally, the consideration of the distinct features associated with each grief story may also help us understand the individual processes of loss integration and post-mortem connection. One of the features that may be taken into consideration is the amount of time to integrate loss. For example, Field and Friedrichs (2004) found that widows who were grieving for longer than 2 years showed a more comforting relationship with the deceased when compared to widows whose husbands died more recently. In Rose's case, in addition to the loss of her son 3 years ago, she is also dealing with the recent and tragic loss of her husband, which may further challenge the integration of loss in a scenario of grief overload (Neimeyer & Holland, 2006). Likewise, circumstances related to the death of Rose's relatives might also impact the distinctiveness of her pattern of change. Recent research suggests that the losses associated with untimely (e.g., loss of a child) or violent deaths (e.g., fatal accidents) may increase the risk of complicated grief symptomatology (Lichtenthal, Cruess, & Prigerson, 2004; Stroebe, Schut, & Stroebe, 2007) as they are associated with greater difficulty to construct a healthier understanding of these events (Currier et al., 2007; Currier, Holland, & Neimeyer, 2006). Therefore, in conjunction with the recognition of client's ambivalence or self-protection throughout the change process (Engle & Holiman, 2002), the therapist may also contemplate the distinct risk factors of each grief client as important aspects of the therapy (Keese et al., 2008; Stroebe, Folkman, Hansson, & Schut, 2006).

Although only Emily showed a significant clinical change in all outcome

measures at the end of therapy (considering the RCI), Rose showed symptomatic improvements, especially in the BDI-II and in the OQ-45.2, decreasing 14 points in the ICG from pre to post treatment phases. This may indicate that the recurrence of ambivalence may not necessarily inhibit the change process, even though it could inform the therapist about the most painful and key aspects that need to be further worked on in therapy. For example, if we consider the Dual Process of Bereavement from Stroebe and Schut (1999), it is proposed that the griever's choice to avoid negative emotions as intense pain, sadness, anger, guilt (as a time off on the loss-orientated response) may potentiate the process of life restoration (investing in more positive emotions, plans, projects). In this sense, we could look at Emily and Rose's RPMs (both in "Integration" and "Proactivity" protonarratives) as an evidence of this process of back and forth from loss integration and life reorganization, respectively. According to this line of reasoning, the emergence of ambivalence in grief psychotherapy could reflect the way clients respect their own timing of change towards grief adaptation, which also needs to be integrated in the therapeutic process.

A final consideration regarding the results of this study addresses the fact that, in 15 sessions, Rose achieved a considerable change in depression but remained relatively stable on complicated grief symptomatology, pointing a distinct timing of change between these two problematics. We hypothesize that this result may be associated with the way she organized an active search for alternative ways of grieving, focused on "being strong and present" for her daughter. Being committed with this goal, she tried different activities (e.g. support groups, grief books) and entered therapy. It may be the case that this active interest and investment in herself and in her daughter's well-being (different from the general loss of interest and sense of worthless in depression) had resonance on her depressive symptomatology. Furthermore, despite the clinical grief symptomatology at the end of therapy, she also decreased 14 points in the ICG (even though not as a recovered case), which may indicate a healthy evolution in her grief symptomatology as well, but in a different timing from depression. It seems to be consistent with recent research suggesting "complicated grief" and "depression" as different problematics (Bonanno, Neria, Mancini, Coifman, Litz, & Insel, 2007; Lichtenthal et al., 2004).

6 LIMITATIONS

One of the main limitations of this study is the fact that the cases have very distinct features regarding the types of loss brought to therapy, which may restrain any attempt to compare the data between them. Also, the results are based only on 2 clients, followed only by one therapist in a non-manualized intervention, which restricts its generalization. In this sense, future studies should be conducted with other cases and samples of grief therapy, followed by different therapists and even with different therapeutic modalities.

Finally, we also consider that the results of this study regarding the association between clients' clinical and narrative change must be carefully interpreted. That is, we consider that it is not possible to establish a causal relationship between the elaboration of IMs, RPMs and clients' clinical progression over time. Given the nature of this research design it is not possible to rule out the contribution of third variables that both explain symptoms' change and the patterns of IMs and RPMs.

Despite these limitations, we believe that this study has provided relevant information regarding the way two different grief clients created innovation and addressed ambivalence, and how these different narrative constructions influenced both the emergence of a healthier story of loss and resulted in symptomatic improvement.

7 FUTURE RESEARCH

Further research is needed regarding the role of ambivalence in grief psychotherapy, exploring how different clients maintain and transform the stories they bring to therapy and how ambivalence may affect the processes of loss integration and life reorganization. Specific case studies addressing the particularities of each grieving process (e.g., time since loss, death circumstances) may provide a deeper understanding of the individual processes of "meaning reconstruction in the experience of loss" (Neimeyer, 2001), and how these narrative processes may facilitate differentiation between beneficial versus problematic attachment with the deceased.

Finally, the exploration of therapists' involvement in the co-construction of

change would also be relevant. Although this study did not focus on the therapist contribution on self-narratives transformation (through IMs) or maintenance (through RPM), a recent study by A.P. Ribeiro, E. Ribeiro, et al., (2012) suggests that the emergence of RPMs (or ambivalent responses) tends to appear when the therapist proposes more challenging interventions, trying to intensify the emergence of IMs. Interpreted as a less supportive movement regarding client's difficulties, it seems to stimulate the emergence of RPMs, perceived as a response of self-protection (Engle & Holiman, 2002) against uncertainty or unfamiliarity (brought by IMs). Regarding this form of resistance in therapy, the authors suggest that the therapist needs to invest in less challenging interventions, being, instead, more empathetic with client's problematic stories and difficulties. Although this association between therapist's interventions and the emergence of RPMs needs to be further studied, it seems to be relevant on addressing the nature and role of RPMs as a co-construction between client and therapist.

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CHAPTER III

INNOVATIVE MOMENTS IN CONSTRUCTIVIST GRIEF THERAPY

CHAPTER III

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1 ABSTRACT

Several studies have proposed that self-narrative transformation occurs through the elaboration of "Innovative Moments" (IMs), which are alternative experiences to the problematic self-narrative. This study aimed to analyze the emergence of IMs among six complicated grief women and to examine associations of IMs to the severity of grief symptomatology, assessed by the "Inventory of Complicated Grief". Eighty-three sessions were analyzed using the "Innovative Moments Coding System" (IMCS). A generalized linear model analysis (GLM) showed a significant association between the emergence of IMs and the interaction between time and symptomatic improvement, indicating a higher rate of IMs production over time in cases with better clinical outcomes. These results reinforce IMs' relevance in studying narrative change among cases with distinct clinical progressions.

2 INTRODUCTION

2.1 Self-narrative transformation in psychotherapy: the emergence of Innovative Moments

In the last decade, researchers have demonstrated an increased interest in how clients' self-narratives change across therapy (Angus & McLeod, 2004; Gonçalves & Stiles, 2011; Luborsky, Singer, & Luborsky, 1975). This perspective of human change assumes that clients act as active storytellers and organize their multiple life experiences into coherent stories – or self-narratives – that they share with others (Angus & McLeod, 2004; Bruner, 2004; Bruner, 1990; Gonçalves, Matos, & Santos, 2009; McAdams, 2001; Neimeyer, Herrero, & Botella, 2006;

[5] This study was submitted to the jounal *Psychotherapy Research* with the following authors: D. Alves, P. Fernández-Navarro, J. Baptista, I. Sousa, E. Ribeiro, & M. M. Gonçalves.

Sarbin, 1986; White & Epston, 1990). According to this narrative approach, self-narratives may become dysfunctional if they lack flexibility and start to exclude relevant experiences of a person's life (see Dimaggio, 2006 for other narrative dysfunctions). Thus, these specific stories or interpretations can narrow persons' understanding of themselves and the world, imposing certain rules that influence the way they behave, think, feel and interact with others.

According to Gonçalves and collaborators (2009), change in psychotherapy occurs as clients transform their previously inflexible or problematic self-narratives into a more functional self-narrative. According to these authors, this transformation process occurs as clients elaborate different "Innovative Moments" (IMs), which are alternative experiences to the ones imposed by the problematic self-narrative.

To track the emergence and development of IMs, Gonçalves and collaborators (2009) developed the Innovative Moments Coding System (IMCS; Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011), a qualitative method that systematically analyzes how IMs emerge throughout the sessions. The method was first applied to a sample of women survivors of partner violence followed in narrative therapy (NT; Matos, Santos, Gonçalves, & Martins, 2009), and it was later applied to other samples from different therapeutic models (e.g., emotion focused therapy – EFT – and client centered therapy – CCT – for depression; Mendes, Ribeiro, Angus, Greenberg, Sousa, & Gonçalves, 2010; Gonçalves, Mendes, Cruz, Ribeiro, Angus, & Greenberg, 2012). In this study, we used the IMCS to analyze how IMs develop in a sample of six complicated grief clients followed in constructivist grief therapy (Neimeyer, 2001; 2006b).

2.2 Innovative Moments Coding System

The Innovative Moments Coding System (IMCS) identifies and differentiates five types of IMs: action, reflection, protest, reconceptualization and performing change. Additionally, it proposes the subdivision of reflection and protest IMs into subtypes 1 and 2 (see Table 1 with examples).

1. *Action IMs* are alternative behaviors and accomplishments that fall outside the behavioral repertoire constrained by the problematic self-narrative.

2. *Reflection IMs* refer to alternative thoughts, understandings and feelings different from what is imposed by the problematic self-narrative. It is subdivided into reflection 1 and 2:

   2.1. Reflection 1(centered on the problem): the person creates distance from the problematic self-narrative by formulating new comprehensions about its causes and effects, aiming to overcome it.

   2.2. Reflection 2 (centered on change): the person elaborates on the change process, for instance, considering the relevance of the therapeutic process and the strategies implemented to achieve self-transformation. Reflection 2 also involves the recognition of the difference between the past (problematic) and actual (alternative) self-narrative and feelings of well-being due to this insight.

3. *Protest IMs* involve new behaviors (such as Action IMs) and/or new thoughts (such as Reflection IMs) centered on criticizing the problematic self-narrative and/or the persons who support it. This active criticism distinguishes protest from action and reflection (e.g., "I don't want this [facet of the problematic self-narrative] anymore, I want to live my life in a different way, that's enough!"). It is subdivided into Protest 1 and 2:

   3.1. Protest 1 (centered on the problem): involves a position of criticism towards the problematic self-narrative or any source that feeds its power (e.g., a person or persons, particular self-positions)

   3.2. Protest 2 (centered on new and empowered self-positions): refers to a position of assertiveness in which the client affirms his or her rights and needs, assuming his or her well-being as an important priority. This new position fosters a sense of authorship and empowerment regarding the change process.

4. *Reconceptualization IMs* incorporate a personal recognition of two aspects of the change process: 1) the contrast between the old self (problematic self-narrative) and the present self (alternative self-narrative) and 2) the awareness of the process that allowed this transformation. Thus, as a more complex and central type, reconceptualization involves not only the client's perception of the contrast between two positions (past and present) but also a meta-perspective position (Dimaggio, 2006) regarding the mechanisms that underlie this transformation.

5. *Performing change IMs* include the elaboration of anticipated or accomplished new experiences, investments, activities or skills that become possible as a consequence of the change process.

Table III. 1: Innovative Moments with examples (Problematic self-narrative: Complicated Grief)

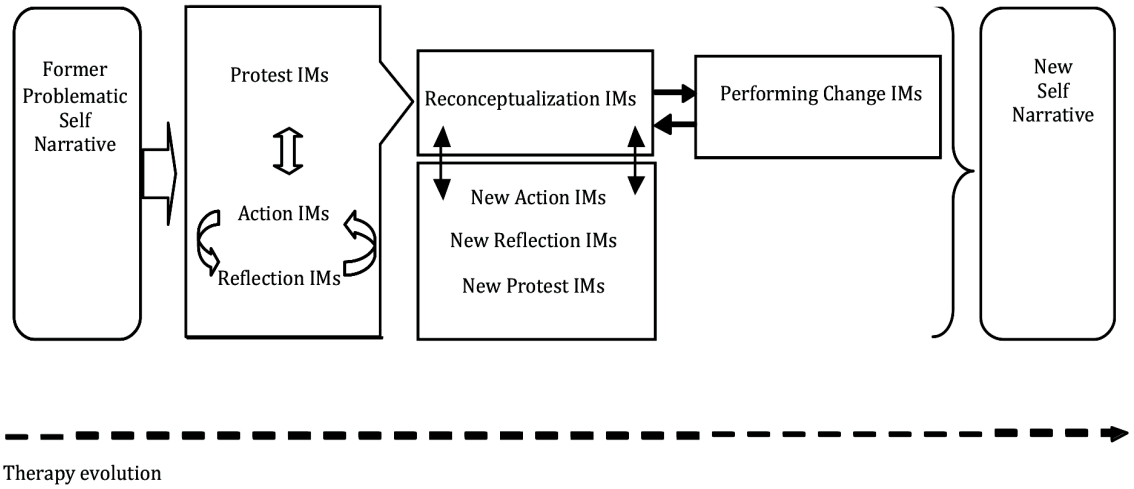
	Contents	Examples
Action	• New coping behaviors facing anticipated or existent obstacles; • Effective resolution of unsolved problem(s); • Active exploration of solutions; • Restoring autonomy and self-control; • Searching for information about the problem(s).	*C: Yesterday… instead of staying in my bed crying all day, I took a ride to the city, visited the church to ask God to help me organize my life.*
Reflection	***Subtype I. Creating distance from the problem(s)*** • Comprehension – Reconsidering causes of problem(s) and/or awareness of its / their effects; • Formulation of new problem(s); • Adaptive self-instructions and thoughts; • Intention to fight demands of problems, references of self-worth and/or feelings of well-being.	*C: I want to live my life in a different way, trying to remember the things my daughter taught me. I'm sure she would say to me "keep going mom, you're on the right track".*
	Subtype II. Centered on the change • Therapeutic Process – Reflecting about the therapeutic process; • Change Process – Considering the process and strategies implemented to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change); • New positions – references to new/emergent identity versions in face of the problem(s).	*C: Our sessions are helping me to accept this situation (the daughter's loss) in a more peaceful way, because now I know that I have strength to do this.*
Protest	***Criticizing the problem(s)*** • Repositioning oneself towards the problem(s).	*C I'm tired of not having the right to cry and talk about my feelings and my sadness in front of others! It has to change!!*
	Emergence of new positions • Positions of assertiveness and empowerment;	*C: I will not wear black clothes everyday just to show others that's I'm grieving! Not anymore! Now I don't care, I wear what I want and no one has nothing to do with it!*

Reconceptualization	Reconceptualization always involves two dimensions: • Description of the shift between two positions (past and present); • The process underlying this transformation.	*C: Let's think, for example, about the Mayan pyramids I climbed a few years ago. At the beginning I was stuck at the middle of the pyramid…But then I realized that I couldn't be on that position forever, so I found a more stable spot…and started to get down slowly. Here (in therapy) it was the same, I didn't know how to deal with her loss and I learned gradually how to accept and (…) how to "go down" slowly into the ground (…) For example I started to give much more value to spiritual rather than physical things, and even if I lost a really beautiful daughter (physically), her actions and the way she helped persons were even much more beautiful (…)She's present in a different way.*
Performing Change	• Generalization into the future and other life dimensions of good outcomes; • Problematic experience as a resource in new situations; • Investment in new projects as a result of the process of change; • Investment in new relationships as a result of the process of change; • Performance of change: new skills; • Re-emergence of neglected or forgotten self-versions.	*C: Now I can feel her presence in my life in a different way, not in her house, in her clothes, or even at the cemetery. Now I feel her presence in my thoughts, in my new life, and I know that she is protecting me, and all my decisions to organize my life count with her strength. In the last week I started to plant new flowers on my backyard. I'm investing in "life" again, seeing these flowers growing every day because of me. She (the daughter) would be very proud of me!*

2.3 The Heuristic Model of Psychotherapeutic Change

In the past few years, several studies in psychotherapy have used the IMCS to explore the processes of narrative change in different samples and therapeutic approaches (Gonçalves, Mendes et al., 2012; Gonçalves, Mendes, Ribeiro, Angus, & Greenberg, 2010; Mendes et al., 2010; Ribeiro, Gonçalves, & Ribeiro, 2009; Santos, Gonçalves, & Matos, 2011; Santos, Gonçalves, Matos, & Salvatore, 2009). Taking into consideration the main results of these studies, Gonçalves and collaborators (Gonçalves et. al, 2009; Matos et. al, 2009) have proposed a heuristic model of narrative change in brief psychotherapy, represented in Figure 1.

Figure III. 1: Heuristic model of change (Gonçalves et al., 2009)



According to this model, the pattern of successful change starts with the emergence of action and reflection IMs, which may appear in different sequences throughout the initial sessions. These are the most elementary IMs, representing clients' explorations of new ways of acting, feeling and thinking outside the problematic self-narrative domain. Protest IMs usually emerge after multiple sequences of action and reflection IMs, also in the first phase of the process. Although action, reflection and protest IMs constitute important forms of innovation, their continuous emergence and re-emergence, per se, seems to be insufficient for the development of an alternative self-narrative (Gonçalves et al., 2009). Reconceptualization, in turn, is recognized as the most complex form of innovation, associated with a meta-perspective or understanding of the particularities of the change process. Reconceptualization is also recognized as the IM that fosters the continuity of the change process by consolidating the meanings of previous IMs and promoting the integration of the following ones (Gonçalves et al., 2009; Gonçalves & Ribeiro, 2012). In this sense, after the emergence of reconceptualization, new cycles of action, reflection and protest IMs emerge, validating the integration of the new self-narrative. Reconceptualization usually emerges in the middle phase of the treatment and progresses gradually until it ends in successful change. Performing change IMs tend to appear after reconceptualization and typically involve the performance of new skills developed due to the change process. Thus, the client is now able to invest in new projects or plans that are not just an attempt to combat or surpass the problem (being, in this way, different from action IMs). Performing Change may also include the re-discovery of vanished parts of the self, as the person

explores the new experiential repertoire. Finally, as reconceptualization and performing change progress, new action, reflection and protest IMs also occur, creating a pattern of congruent new meanings.

In unsuccessful therapy, in turn, the process of change – also initiated with action, reflection and protest IMs – seems to be blocked by the absence of reconceptualization IMs (Alves, Fernández-Navarro, A. Ribeiro, E. Ribeiro, & Gonçalves, in press; Matos et al., 2009; Mendes et al., 2010). These results highlight the role of reconceptualization as a key developmental process in clients' reintegration of painful experiences into a new self-narrative (Cunha, Gonçalves, Valsiner, Mendes, & Ribeiro, 2012).

2.4 Innovative Moments in constructivist grief therapy: previous findings

This study is anchored in the narrative-constructivist perspective that suggests that narrative activity is a central way of integrating the multiplicity of life experiences (even the more difficult life transitions) in a coherent, stable and flexible self-narrative through which persons give meaning to their lives (White & Epston, 1990; Neimeyer & Levitt, 2001). However, as suggested by Neimeyer (2002, 2006a), significant losses may menace this self-stability as the loss of a significant person may be an incoherent experience that contradicts the person's expectations about his or her life. When the self-narrative is not capable of integrating this event, the person may develop a response of complicated grief (Neimeyer, 2006a). From a psychopathological perspective (Prigerson et al., 1995; Prigerson & Maciejewski, 2006), complicated grief involves a prolonged grieving response characterized by high levels of separation distress, disturbing thoughts about the deceased (e.g. "I can hear his voice blaming me for his death"), significant difficulty accepting the loss and reorganizing life afterwards, and other symptoms that seriously impair the person's global functioning (e.g. persistent difficulty trusting others) (Prigerson et al., 2009).

A good deal of research (Coleman & Neimeyer, 2010; Currier, Holland, Coleman, & Neimeyer, 2007; Keesee, Currier, & Neimeyer, 2008; Lichtenthal, Currier, Neimeyer, & Keesee, 2010; Neimeyer, Baldwin, & Gillies, 2006) suggests that the capacity to integrate loss into the personal self-narrative is a strong predictor of grief adaptation, highlighting the centrality of these meaning-making processes in the grieving experience. In the past few years, there has been a growing number of

empirical studies supporting the effectiveness of meaning-oriented interventions in complicated grief (Lichtenthal & Cruess, 2010; MacKinnon et al., 2011; MacKinnon et al., 2012). This meaning reconstruction approach (Neimeyer 2001, 2006b) offers a reflective context for helping clients acknowledge and renegotiate the meanings of their experiences, in a more experiential, co-constructed and creative – rather than "cognitive" or corrective – way (Neimeyer, 2009; Neimeyer, Burke, Mackay and van Dyke-Stringer, 2010). It proposes the reconstruction of clients' problematic self-narratives (inflexible stories of loss) and the investment in a more flexible self-narrative, capable of incorporating more positive and adaptive meanings of their losses (Neimeyer et al., 2010).

Considering the relevance of these constructivist-narrative approaches in transforming clients' stories of loss, recent studies using the IMCS in constructivist grief therapy have been developed that explore how narrative novelties (IMs) emerge throughout therapy and how they promote change. In a good-outcome case of constructivist grief therapy with a bereaved mother, Alves, Mendes, Gonçalves and Neimeyer (2012) found that the emergence and development of IMs were associated with the client's progressive clinical change, as the client gradually transformed the problematic self-narrative into a more healthful story of loss. Mostly elaborating on reflection IMs throughout therapy, this client gradually progressed to reconceptualization at the middle phase of the process, finishing by elaborating on new life investments through performing change IMs. In general, the results of this study corroborated the heuristic model of change presented earlier. The general absence of protest IMs throughout the entire process was portrayed as the main difference from previous IMCS studies. According to the authors, its absence could be associated with the constructivist view of complicated grief, pointing to the acceptance and integration of loss as the main therapeutic goal, rather than the elaboration of a position of criticism towards the story of loss.

Another recent study using the IMCS in two constructivist grief cases was developed (Alves et al., in press), analyzing how a "recovered" case of a woman who lost her grandmother and an "improved but not recovered" case of a woman who lost both her son and her husband changed their stories of loss in therapy. The results of this study were globally consistent with the heuristic model of change (Gonçalves e al., 2009), with the "recovered" case progressing from reflection to reconceptualization in the more advanced stages of therapy, contrasting with the

relative absence of reconceptualization in the "improved but not recovered" case. This study also explored how IMs were organized around central themes or protonarratives (Ribeiro, Bento, Salgado, Stiles, & Gonçalves, 2011) that emerged throughout treatment, which were different from the themes of the problematic self-narrative. The results showed the emergence of two central themes involved in the process of self-transformation in both cases: "Integration" and "Proactivity". "Integration" was the most salient theme in both therapeutic processes, incorporating all IMs that addressed the client's construction of a healthier symbolic connection with the deceased, integrating loss in a more representational way (e.g., "*Now I feel that she's with me in another way … I can even look at her picture on the grave and feel peace*"). The centrality of this theme is congruent with the findings from Keesee et al. (2008) and Lichtenthal, Currier et al. (2010), pointing to the capability to "make sense of" and integrate loss as a central aspect in bereavement adaptation. It is also in line with the "loss orientation" process proposed by Stroebe and Schut (1999) in their "Dual Process Model", addressing the relevance of griever's concentration on exploring the multiple meanings and challenges of loss itself, including how to reestablish a different connection with the lost person. Finally, "Proactivity" incorporates all IMs addressing the client's search for moments of well-being and life reconstruction as alternatives to the problematic story of loss (e.g., "*I'm trying to do other things, not being always at home…Sometimes I go for a walk with some friends*"). This theme also seems to be consistent with the "Dual Process Model" (Stroebe & Schut, 1999), more specifically with the "restoration orientation" phase, which is focused on grievers' investments in life restoration (new roles, relationships, activities) as a way to cope and adapt to the multiple life changes after loss. According to this model, the oscillation between "loss orientation" and "restoration orientation" is necessary for adaptive grieving. Due to the relevance of these processes and how they can inform us about the client's movement toward positive grief adaptation, "Integration" and "Proactivity" will also be explored in this study.

2.5 The Present Study

The overall purpose of this study is to investigate how IMs – as opportunities for self-transformation – occur throughout therapy and how their emergence and expansion are associated the themes "Integration" and "Proactivity", identified as

relevant processes in loss adaptation (Alves et al., in press).

In general, we anticipate that the global pattern of IMs in this sample will be consistent with the heuristic model of change (Gonçalves et al., 2009), thus being congruent with the findings from previous studies in NT, EFT, CCT and constructivist grief therapy (CGT). Because one of the central goals of CGT (Neimeyer, 2001; 2006b) is the promotion of new understandings of loss (Neimeyer, 2001), we hypothesize a high prevalence of reflection IMs in all cases, expressing clients' investment in the meaning reformulation of this experience. We also anticipate a higher probability of reconceptualization IMs occurring in cases with greater symptomatic improvement (pre-post clinical scores). Finally, considering the promotion of a healthier connection with the deceased and the stimulation of new forms of life reorganization as central aspects of CGT (Neimeyer, 2001; 2006b), we anticipate a gradual evolution of "Integration" and "Proactivity" across therapy, with a higher probability in cases with greater symptomatic improvement.

Considering the hypothesis addressed above, the main research questions of this study are as follows:

1. Is the IMCS a reliable method to identify IMs in CGT?
2. Are there significant differences in the probabilities of *overall IMs* occurring over time (throughout the sessions) among cases with different symptomatic improvements?
3. Are there significant differences in the probabilities of *specific IMs* occurring over time among cases with different symptomatic improvement?
4. Are there significant differences in the probabilities of each theme occurring over time in cases with different symptomatic improvement?

3 METHOD

3.1 Clients

Clients were recruited from our "Complicated Grief Research Study", designed to explore the processes of narrative change in constructivist grief therapy (CGT; Neimeyer, 2001; 2006b). It has been established a protocol with the main hospital and with two health centers of our city in order to enroll clients that evidenced a problematic response to a significant loss to psychological assessment at the clinical psychology center of our university. From this evaluation meeting, clients were then

assigned to grief intervention, or to another intervention (available at the university center) if complicated grief was not the central problematic. In this research, 2 dropouts were registered, one of them at the end of the process (at session 11, in which the client no longer manifested clinical symptoms, saying that it was difficult to continue coming to therapy with her husband being sick) and the other one at the beginning of the therapy (4º session), as the client no longer appeared to therapy.

Each recruited client was followed weekly in individual constructivist grief therapy (Neimeyer, 2001; 2006b) during 15 sessions as established in the clinical trial protocol. The sessions were video recorded and transcribed, and all clients gave permission for their materials to be used (informed consent was obtained from all clients). The ethical committee of the local hospital (the institution that referred clients for treatment) approved this research.

In this study, 6 CGT cases were analyzed (this included the two cases from the study referred previously, from Alves et al., in press). These 6 cases were those with complete treatments and data sets for process analysis. All 6 clients were Caucasian women (age range = 20-62 years, *M* = 42 years, *SD* = 18.63) and completed an average of 13.83 (*SD* = 0.98) sessions. At the time of case selection, it was established that the analysis of pre-post therapy changes would be based on the Inventory of Complicated Grief (ICG; Prigerson et al., 1995; Frade et al., 2009) and the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996; Portuguese version by Coelho, Martins, & Barros, 2002).

Among the clients included in this sample, five had lost one significant person, and one client had lost two significant persons. At the pre-therapy assessment meeting, the 6 cases presented with the following circumstances, causes and time since loss: loss of a grandmother to a stroke, three years before therapy (case 1); loss of a boyfriend to cancer, two years before therapy (case 2); loss of a husband to cancer, two years before therapy (case 3); loss of a daughter to cancer, two years before therapy (case 4); loss of a son to cancer, (three years before therapy) and husband (who was run over by a car, six months before therapy) (case 5); and loss of a mother to a stroke one year before therapy (case 6). Two clients maintained stressful relationships with other family members (e.g., economic and marital problems) that also had an impact on their mental well-being, although these difficult relationships were not as central as the complicated grief. Work on these relationships areas were also privileged throughout their treatment.

3.2 Therapist

All clients were followed by the same female therapist, a 26-year-old clinical psychology doctoral student with three years of prior clinical experience as a psychotherapist and two years of experience in constructivist psychotherapy with grief clients. A trained therapist with 18 years of clinical experience as a constructivist psychotherapist supervised the clinical practice to ensure adherence to the constructivist therapeutic model. The supervision took place three to four times *per* month, and it was based on a structured verbal report of each session. This periodicity was adjusted in order to accommodate all the video recorded sessions of the previous week. Every supervision meeting was also oriented to conjointly organize the therapeutic activities of the next sessions with each client, privileging, this way, the adherence to the constructivist intervention model. However, no specific adherence scale was used.

3.3 Constructivist Grief Therapy

The therapy was conducted according to the constructivist meaning reconstruction approach proposed by Neimeyer (2001; 2006b). Although the treatment was not oriented through a structured manual, it always included an initial exploration of the client's experience of loss, oriented by the "Meaning Reconstruction Interview" (Neimeyer, 2006b, pp.166-169). This first contact aimed to explore and validate the multiple challenges and resources of each client. Then, the therapeutic process developed through the articulation of several narrative-constructivist activities (e.g., "narrative retelling"; Neimeyer et al., 2010, p.76, "imaginal conversations with the deceased"; Shear, Boelen, & Neimeyer, 2011, p.149), implemented in order to foster a less anguished elaboration of grief (Neimeyer et al., 2010) and the construction of a more positive connection with the deceased (Field, 2006; Shear et al., 2011).

3.4 Researchers

Three judges with practice in IM coding procedures were involved in the IM coding process of this sample. Judge 1 analyzed the IMs in all 6 cases, judge 2 coded all IMs from 3 cases and the third judge coded all IMs from 2 cases. All three judges were doctoral students in clinical psychology. Finally, two university members in

clinical psychology and skilled researchers and psychotherapists supervised and contributed to the elaboration of this study.

3.5 Measures

3.5.1 Outcome measures

Structured Clinical Interviews for DSM-IV-TR, *Axis I* (SCID-I; First, Spitzer, Gibbons, & Williams, 2002) and *Axis II* (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). Grounded in DSM-IV-TR diagnostic criteria, SCID-I and SCID-II are structured clinical interviews that assess clients' disorders on axis I (mood, psychotic and anxiety disorders) and axis II (personality disorders). SCID-I also enables the collection of relevant demographic and clinical data about the participants. Inter-rater reliability ranged from .83 to .85 on the SCID-I (Del-Ben et al., 2001) and was .63 on the SCID-II (Weertman, Arntz, Dreessen, Velzen, & Vertommen, 2003).

Inventory of Complicated Grief (ICG; Prigerson et al., 1995). The ICG is a 19-item questionnaire to assess the severity of grief symptomatology. The items (e.g. "I feel that life is empty without the person who died") are rated on a 5-point Likert scale, from 0 ("never") to 4 ("always"), with total scores ranging from 0 to 76. A score above 25 at least 6 months after loss suggests complicated grief. The instrument shows good internal consistency (.94; Prigerson et al., 1995). We used the Portuguese adaptation by Frade, Pacheco, Sousa, and Rocha (2009), which also presents good internal consistency (.91; Frade et al., 2009). The cut-off score for the Portuguese population is 30 (Sousa & Rocha, 2011). The internal consistency of the ICG in the present study was .84.

Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996). The BDI-II is a 21-item questionnaire that assesses the severity of depressive symptomatology over the previous 2 weeks. The items (e.g. self-dislike, pessimism) are rated on a 4-point Likert scale, from 0 to 3, with total scores ranging from 0 to 63. The instrument shows high internal consistency (.91; Steer, Brown, Beck, & Sanderson, 2001). We used the Portuguese adaptation by Coelho, Martins and Barros (2002), with a cutoff of 14.29 and a Reliable Change Index (RCI, Jacobson & Truax, 1991) of 8.46, as proposed by Seggar, Lambert, and Hansen (2002). The internal consistency of the BDI-II in the present study was .71.

3.5.2 Process Measures

Innovative Moments Coding System (IMCS; Gonçalves, Ribeiro, Matos, Santos, & Mendes, 2010; Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011). The IMCS (Table 1) is a qualitative method of analysis that identifies 5 categories of Innovative Moments (IMs): action, reflection, protest, reconceptualization and performing change. Previous studies with the IMCS (Gonçalves, Mendes et al., 2012; Matos et al., 2009; Mendes et al., 2010) reported reliable agreement between judges in IM coding, with Cohen's kappa between .86 and .97. (Reliability for this study is reported at the results' section).

3.6 Procedures

Outcome measures

In the first meeting with the therapist (assessment meeting), all clients were evaluated with the SCID-I (First et al., 2002) and SCID-II (First et al., 1997) clinical interviews to assess co-morbidity with other psychological problems that could be clinically more central than the complicated grief. To screen specifically for complicated grief symptoms, the Portuguese version of the ICG (Frade et al., 2009) was administered. Considering the relationship between grief distress and depressive symptomatology (Bonanno & Mancini, 2006), clients' depressive symptoms were also assessed using the BDI-II (Coelho et al., 2002). Both the ICG and the BDI-II were then administered every fourth session as well as in the final session and at the 6-month follow-up meeting.

All 6 clients were diagnosed with complicated grief in the assessment meeting. Five of them were also diagnosed with major depression, as defined by the DSM-IV (American Psychiatric Association, 1994). Table 2 shows the pre and post ICG and BDI-II scores for each case.

Table III. 2: ICG (cut-off score 30) and BDI-II (cut-off score 14.29) pre and post scores

Case	Pre-test ICG	Post-test ICG	Improvement in the ICG	Pre-test BDI-II	Post-test BDI-II	Improvement in the BDI-II
Case 1	42	11	31	26	8	18
Case 2	39	25	14	14	13	1
Case 3	61	28	33	24	18	6
Case 4	58	21	37	23	12	11
Case 5	55	42	13	35	15	20
Case 6	51	36	15	33	13	20

Considering the cut-off score of 30 established for the Portuguese version of the ICG (Sousa & Rocha, 2011), four cases (cases 1, 2, 3 and 4) showed a clinical change in complicated grief, with final scores lower than 30, while two cases (cases 5 and 6) didn't achieve a clinical change in complicated grief symptomatology at the end of treatment. Finally, considering the BDI-II cutoff score of 14.29 (Coelho et al., 2002) and the *Reliable Change Index* (RCI; Jacobson & Truax, 1991) of 8.46 proposed by Seggar et al., (2002), three cases (cases 1, 4 and 6) showed a significant clinical change in depressive symptomatology while two cases (cases 3 and 5) didn't achieve a significant clinical change in depressive symptomatology at the end of treatment.

Despite research evidence suggesting comorbidity between complicated grief and Post-Traumatic Stress Disorder (PTSD; McDevitt-Murphy, Neimeyer, Burke, & Williams, in press), none of the cases met the criteria for a PTSD diagnosis.

Process measures

Innovative Moments Coding System (IMCS): IMs identification, coding and reliability

In this study, the IMCS was applied to a total of 83 sessions, corresponding to all sessions of the 6 CGT clients. Judge 1 independently coded 100% of the sample (the 6 entire cases, 83 sessions), judge 2 independently coded 50.6% of the sample (3 cases, 42 sessions) and judge 3 independently coded 33.7% of the sample (2 cases, 28 sessions). Judges 2 and 3 were unaware of cases' clinical outcomes in all the instruments applied.

The IM coding procedure involved 1) a consensual definition of the client's problematic self-narrative(s) between judges; 2) identification of IMs within the

transcripts, recording the number of words involved in each one; and 3) categorization of each IM by type.

1) Consensual definition of client's problematic self-narrative(s)

The problematic self-narrative was evaluated from the perspective of what therapist and client discussed during therapy, having in mind what were they main therapeutic targets. This evaluation was done in a consensual way, using the contributions of all judges. That is, each judge organized an independent list of problems that was discussed in order to generate a consensual list of problems from which the facets of the problematic self-narrative were defined. This final definition of this list of problematic facets oriented, then, the recognition of IMs (as exceptions to it).

2) Identification of IMs along the text

After the consensual establishment of each client's problematic self-narrative(s) facets, all sessions were independently coded according to their sequential order. The identification of IMs occurred every time the therapist or client started to elaborate upon exceptions to the problematic self-narrative. It was considered that an IM ended when the person stopped elaborating this content. Each IM onset and offset was then identified and the amount of words involved in each one was recorded. The therapist's words were also recorded, given our perspective on the co-constructed nature of the change process (Angus, Levitt, & Hardtke, 1999; Neimeyer, 2009). In this sense, the IM elaboration could result from questions or activities proposed by the therapist, but they were only coded if the client accepted and further elaborated upon it.

3) Categorization of each IM in terms of type and salience

After the IMs were identified, their types were categorized. Some IMs' types may be easier distinguished if we consider the timing of client's progression towards change in which they emerged. Considering action and performing IMs, for example, it is important to highlight that action IMs involve specific actions or behaviors that counter the problem and that have the potential to create new meanings (e.g. in a complicated grief mother who lost her daughter: "*Yesterday I woke up feeling very confused about her loss, but instead of staying in my bed crying all day, I took a ride to the city, visited the church to ask God to help me organizing my life"*). This was an

action taken in order to create alternatives to her life, different from the ones postulated by the problematic story of loss. Performing change IMs, in turn, include new projects, aims, activities, or experiences that were not possible before, given the restrictions imposed by the problematic self-narrative. They represent a performance of the change process and may function as a projection of a new intentions, purposes, and goals that were developed after overcoming the problematic experience. (e.g. from the same bereaved mother presented above: "*Now I can feel her presence in my life in a different way, not in her house, in her clothes, or even at the cemetery. Now I feel her presence in my thoughts, in my new life, and I know that she is protecting me, and all my decisions to organize my life count with her strength. In the last week I started to plant new flowers on my backyard. I'm investing in "life" again…*). The coding of performing change implies the presence of a marker of change, that is, the client has to narrate the perception of some meaningful transformation (in this example, the transformation is centered on the investment in a new and more symbolic way to connect with her daughter).

To compute each IM's salience – that is, the amount of text involved in the elaboration of IMs – the authors calculated the following items:

a. The salience of each type and subtype of IM for each session, corresponding to the percentage of words in the session devoted to each IM. Salience was computed by calculating the number of words involved in each type and subtype, divided by the total number of words in the transcript of the session.
b. Overall salience of the IM, calculated as the sum of all words incorporated into IMs in a given session (independent of the type or subtype), divided by the total number of words of the session.
c. The mean salience for the entire case, by IM type, subtype and overall, calculated as a mean of the percentage of each type and subtype and the overall IMs.

The percentage of agreement between judges regarding overall salience of IMs was calculated as the amount of overlapping words identified by both judges as being from IMs, divided by the total amount of words identified by each judge. The agreement between judges for the specific type of IM was assessed with Cohen's kappa. To further explore the details of the IMCS' administration, please see

Gonçalves, Mendes et al., 2012; Gonçalves, Ribeiro, Mendes et al., 2011; Matos et al., 2009 and Ribeiro et al., 2011.

Thematic Analysis: themes identification and coding

The thematic analysis (Braun & Clarke, 2006) was used in order to integrate each IM coded into the categories pre-established as relevant to loss adaptation in a previous study (Alves et al., in press). The types of IMs were established prior to this analysis. This process involved repeated readings of the transcripts followed by an intensive analysis of each IM's content. Thus, each IM from all 6 cases (83 sessions) was then integrated into one of the themes pre-established as relevant to loss adaptation: "Integration" and "Proactivity". Those IMs whose content was not associated with either "Integration" or "Proactivity" were referred to the category "Others". Further explanation regarding the description of each theme will be provided in the results section. Judges 1 and 2 coded the themes of the same 3 cases they had previously coded, reaching a consensus regarding the final coding decision. Judge 1 individually coded the themes of the other 3 cases.

4 RESULTS

4.1 Can the IMCS be a reliable method to identify IMs in constructivist grief therapy?

A total of 3293 IMs were identified in this sample using the IMCS. The percentage agreement in the overall salience of IMs in the cases coded by judges 1 and 2 was 89.2%, and between judges 1 and 3, it was 83.7%. Both results indicate a high degree of consensus regarding the number of words coded as belonging to IMs throughout the cases, independent of the specific type.

Reliability for the specific types of IMs assessed by Cohen's kappa was .91 between judges 1 and 2 and .80 between judges 1 and 3. Reliability on reflection and protest types (1 and 2) was .83 between judges 1 and 2 and .79 between judges 1 and 3. These results indicate a strong agreement among coders regarding IMs types (Hill & Lambert, 2004).

The mean overall salience of the IMs in this sample was 22.9%. Reflection IMs represented 17.5% of the text coded as IMs, divided almost equally among subtype 1

at 9.2% and subtype 2 at 8.3%. Reconceptualization was the second most salient IM (3%). The total salience of the other IMs was lower than 2.5%.

4.2 Are there significant differences in the probabilities of overall IMs occurring over time (throughout sessions) among cases with different symptomatic improvement?

Similar to the study design proposed by Gonçalves, Mendes, et al. (2012), the data were explored using a generalized linear model (GLM) analysis, considering the salience of each type of IM as the response variable, and "time" along treatment, the "symptomatic improvement" and the "interaction between time and symptomatic improvement" as explanatory variables. The analyses described in this study (GLM analysis) are similar to a regression analysis, with the difference that measures along treatment were used, allowing this way to identify longitudinal patterns.

Taking into consideration the central goal of studying the development of IMs in grief change, we decided to consider grief symptomatology (assessed with the ICG) as the sole explanatory variable for clients' symptomatic improvement. Thus, we did not include the depressive symptomatic improvement as another explanatory variable, although we considered it to be relevant information for sample pre and post-intervention characterization.

Based on the GLM analysis, the probability of "non-occurrence of an IM" or the "occurrence of a certain type of IM" was illustrated as a binary response variable 0/1. It was treated as a random variable with Bernoulli distribution, and the main goal was to infer the probability parameter associated with this distribution. A generalized linear mixed effects model was adopted, incorporating a subject-specific random effect to take into account variability among individuals. A correlation between measurements from the same subject was expected.

According to the literature, we estimated that the occurrence of an IM of a certain type (explanatory variable) is:

$$P\ (occurrence\ of\ an\ IM\ of\ a\ certain\ type) = \mu$$

where the explanatory variables have a linear effect on the probability through a link

function so that:

$$\mu = (\exp(\eta))/(1 + \exp(\eta))$$

The interpretation of η is the logarithm of the odds ratio between occurrence and non-occurrence of an IM; more specifically:

$$\eta = \log(\mu/(1 - \mu))$$

The explanatory variables were then considered: $\eta = \beta \times X$, in which the vector X is of all the significant explanatory variables, and β the vector of the parameters to be estimated.

The process of fitting the data to this model showed that the selected model resulted, which included only the significant explanatory variables; more specifically:

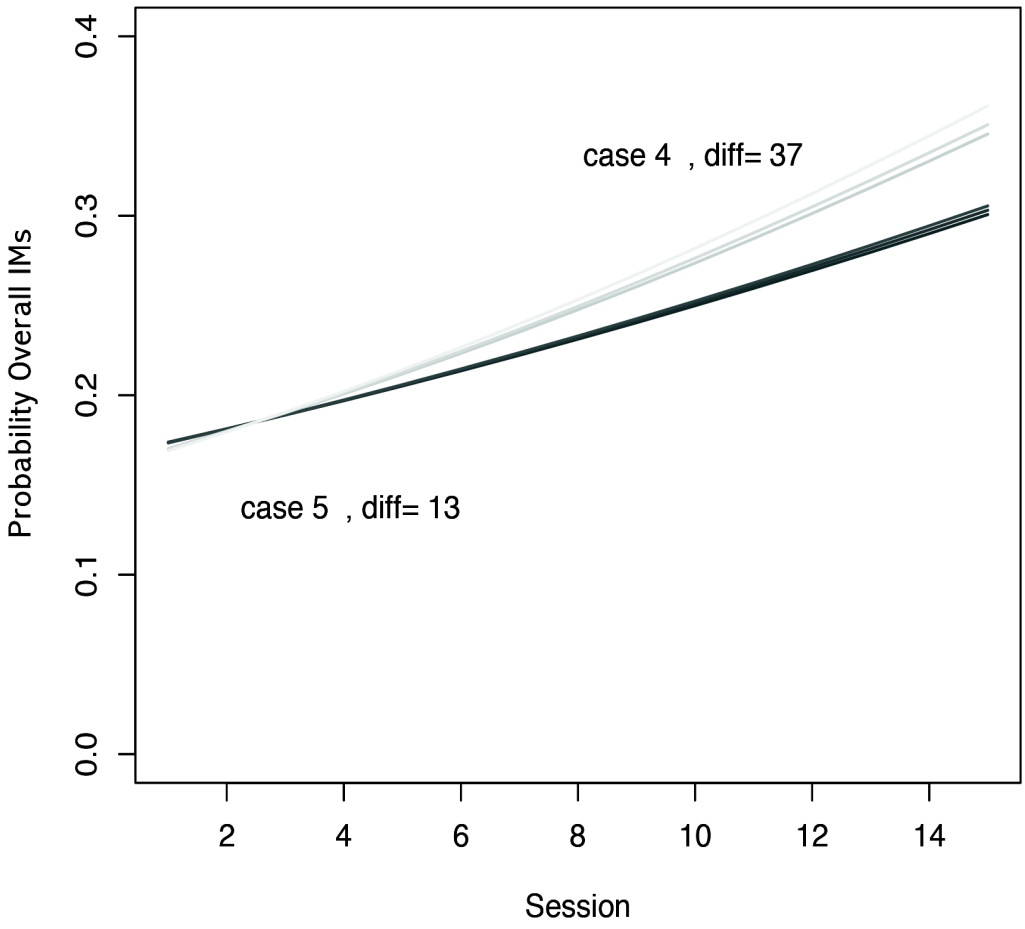
$$\eta = \beta 0 + \beta 1 \times \text{Session} + \beta 2 \times (\text{ICG\_pre} - \text{ICG\_post}) + \beta 3 \times \text{Session} \times (\text{ICG\_pre} - \text{ICG\_post})$$

in which β1*session is the effect of time (the evolution of treatment from session 1 to the last session), β2*(ICG_pre – ICG_post) is the improvement in complicated grief symptoms (that is, the difference between the initial and final ICG scores), and finally, β3*Session*(ICG_pre – ICG_post) is the interaction of time with the improvement in symptoms.

The data for each type of IM were modeled independently with the GLM model. This model enabled the analysis of the various parameters indicated above regarding the overall probability of occurrence of IMs, as well as the probability of each specific IM type. Parameter 1 (β1*session) allowed for a study of the impact of time in the probability of IM emergence, exploring whether the probability of IMs increased or decreased during the treatment. Parameter 2 (β2*(ICG_pre – ICG_post)) allowed for a study of the impact of grief symptomatic improvement on the probability of IM occurrence. Finally, parameter 3 (β3*Session*(ICG_pre – ICG_post)) enabled an analysis of the interaction between time and grief symptomatic improvement. That is, symptom improvement may not had the same impact on the probability of IMs occurring during treatment (it may change its rate).

The results for overall IM probability are illustrated in Figure 2.

Figure III. 2: Probabilities of overall IMs



Axis *y* depicts the probability of overall IM occurrence, and axis *x* depicts the evolution of therapeutic sessions over time. The different grey gradients of the lines represent the level of pre to post-assessment improvement in ICG scores. The lighter lines represent cases with the greatest symptomatic improvement (the lighter line at the top of Figure 2, for example, depicts the results from case 4, the one with the highest pre-post difference (37 points) in the ICG). The darker lines, on the other side, represent cases with lower improvement (the line at the bottom of Figure 2 depicts the results from case 5, the one with the lowest pre-post difference (13 points) in the ICG). The other lines with different degrees of grey in between these extremes represent the other 4 cases. This representation through distinct gradients of grey will

be consistent throughout all figures and only cases 4 and 5 (the ones with extreme pre-post differences in the ICG) will be labeled[6].

The GLM analysis for overall IMs showed that the parameter "symptomatic improvement" had no significant effect on the probability of overall IMs ($p = .897$). In contrast, the parameters "time" ($p < .0001$) and "interaction between time and symptomatic improvement" ($p < .0001$) both had significant positive effects in the overall probability of occurrence of IMs, meaning that cases with different symptomatic improvements started to significantly differ from each other as the therapeutic process progressed. As shown in Figure 2, despite the similarity in IMs probability from baseline until session 6, from this moment onwards, cases with greater symptomatic improvement (illustrated by the lighter grey lines) changed the probability of having IMs with a higher rate over time than cases with less improvement (illustrated by the darker lines).

4.3 Are there significant differences in the probabilities of specific IMs occurring over time in cases with different symptomatic improvement?

In general, the results showed that the IMs with the lowest probability of occurrence were action, protest 1 and protest 2, all with probabilities lower than 1%. Performing Change IMs had a maximum probability of occurrence of approximately 3.5% in the last session of case 4 (the case with the highest symptomatic improvement). Reflection 1, reflection 2 and reconceptualization, in contrast, were the IMs with the highest probability of occurrence, with maximum probabilities of approximately 13%, 15% and 25%, respectively. Given the differences in the probabilities of different types of IMs, we concentrated our analysis just on those IMs that were most prevalent, that is, reflection 1, reflection 2, reconceptualization and performing change.

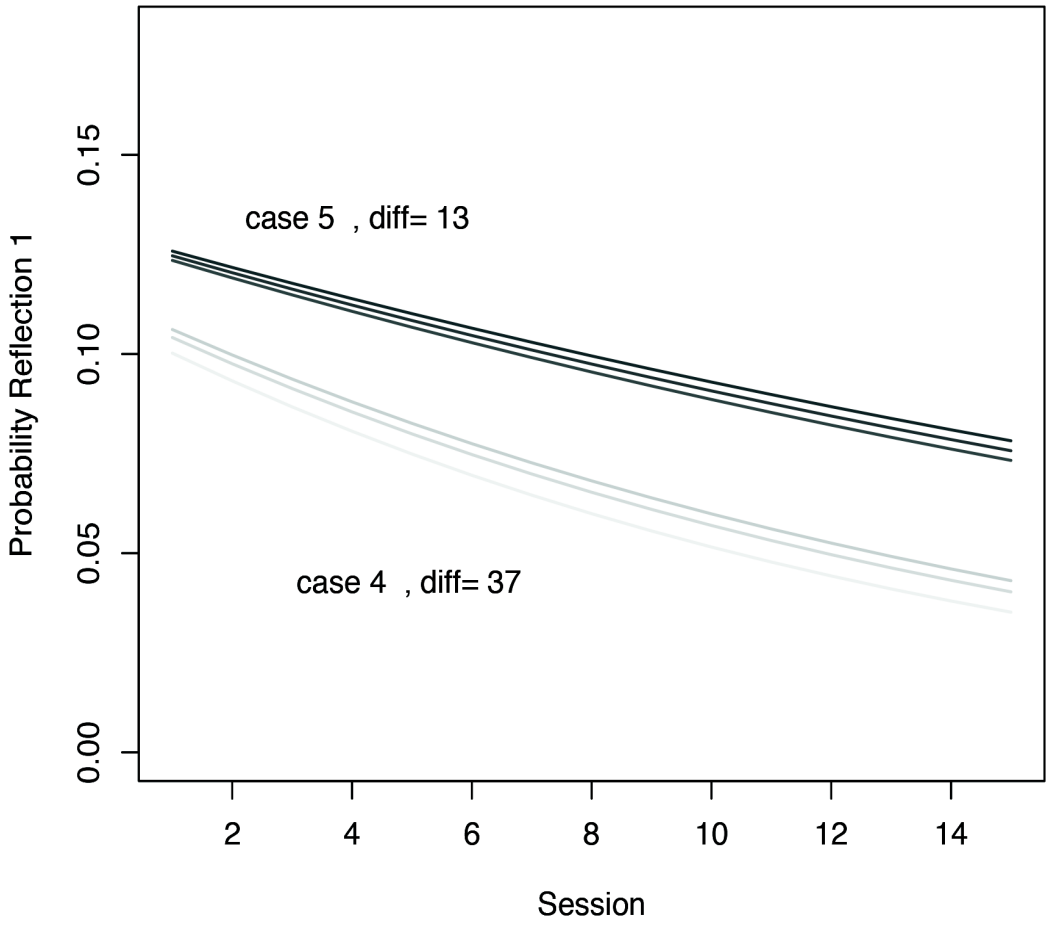
[6] Please notice that, as the results of the three cases with lower symptomatic improvement (depicted by the darker grey lines) were very similar, the three lines corresponding to these three cases overlapped in some figures, appearing just one darker line.

The GLM analysis showed that, similar to what occurred with the overall IMs, the parameter "symptomatic improvement" had no significant effect on the probability of reflection 1 (p = .622), reflection 2 (p = .33) and reconceptualization (p = .681). Performing change was the only IM in which the parameter "symptomatic improvement" showed a significant positive impact (p < .0001). The parameters "time" and "interaction between time and symptomatic improvement", in contrast, had significant effects on the probability of reflection 1, reflection 2 and reconceptualization, which will be explored below.

4.3.1 Reflection 1

The results of reflection 1 (mainly centered in clients' intentions to live grief in a different way) are illustrated in Figure 3.

Figure III. 3: Probabilities of reflection 1 IMs

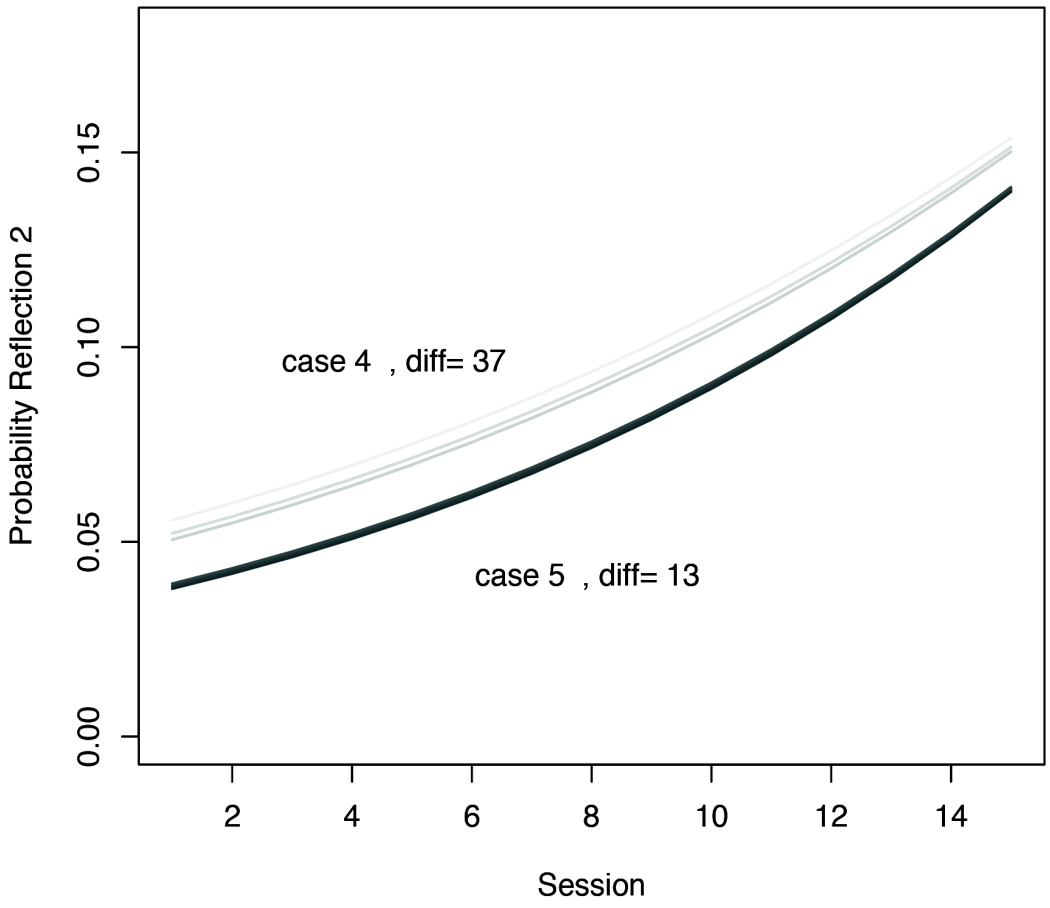


Both "time" ($p < .0001$) and the "interaction between time and symptomatic improvement" ($p < .0001$) negatively affected its probability of occurrence. That is, the probability of reflection 1 decreased progressively from the beginning to the end of the treatment, with cases with greater symptom change (ICG) having a faster reduction in this IM than cases with lower symptomatic improvement.

4.3.2 Reflection 2

Unlike their negative impact on reflection 1, the parameters "time" ($p < .0001$) and "interaction between time and symptomatic improvement" ($p < .0001$) positively affected the probability of occurrence of reflection 2 (mainly centered in clients' elaboration about the strategies implemented to live grief in a more adaptive way). As illustrated in Figure 4, the probability of this IM gradually increased over time in all cases, with a higher rate of change in cases with greater symptomatic improvement (depicted by the lighter grey lines). For example, in case 4 (the case with greatest symptomatic improvement), the probability of reflection 2 progressed from approximately 6% at baseline to 15% in the last session, which was the maximum probability reached by this IM in the entire sample.

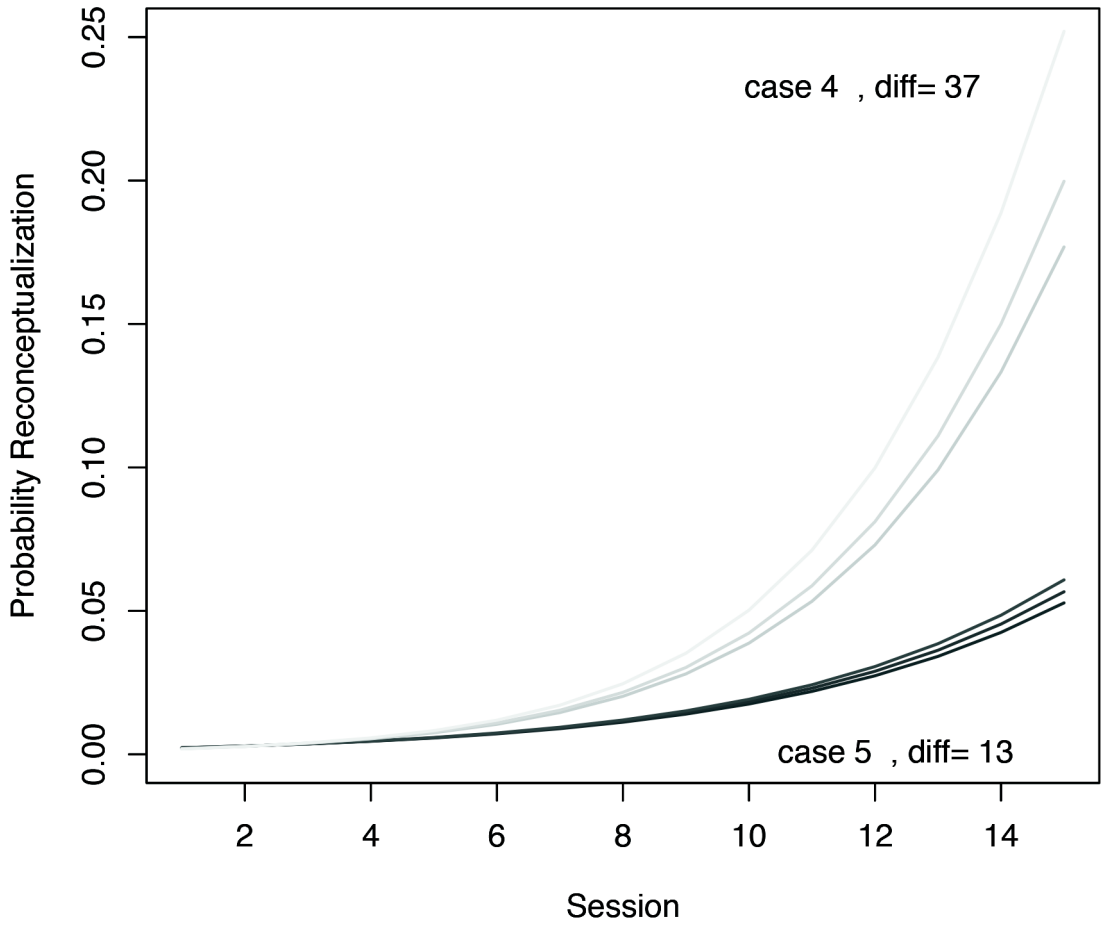
Figure III. 4: Probabilities of Reflection 2 IMs



4.3.3 Reconceptualization

Similar to reflection 2, reconceptualization was also positively affected by the parameters "time" ($p < .0001$) and "interaction between time and symptomatic improvement" ($p < .0001$). As shown in Figure 5, from session 6 onwards the rate of increase of this IM was higher in cases with greater symptomatic improvement (depicted by the lighter grey lines), with case 4 reaching the maximum probability of this IM (25%) in the last session.

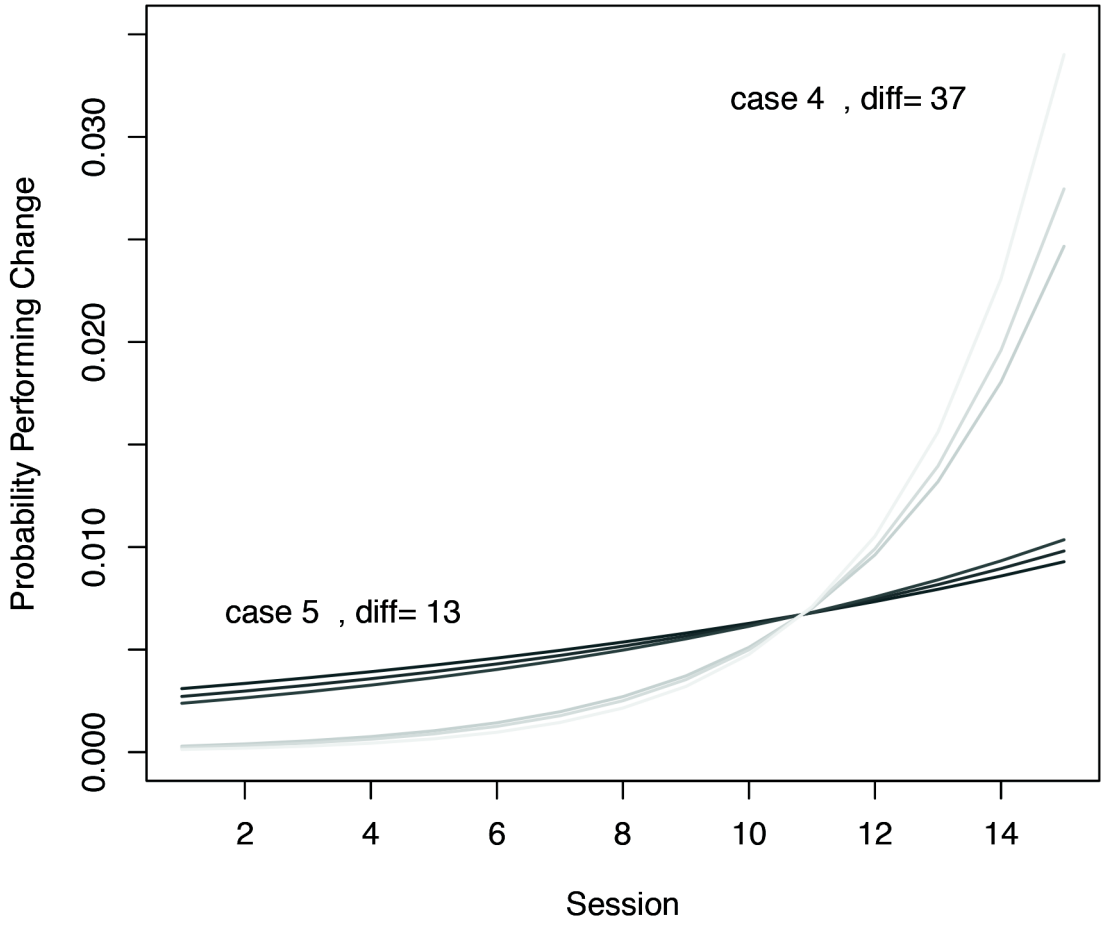
Figure III. 5: Probabilities of Reconceptualization IMs



4.3.4 Performing change

Finally, performing change IMs were positively affected by all parameters studied ($p < .0001$). As seen in figure 6, until session 11, the probabilities were quite similar for all cases, but from session 11 onwards, the cases with greater symptomatic improvement showed a higher rate of increase in this IM. Similar to what occurred with previous IMs, the maximum probability of this IM (3.5%) was reached in the last session of the case that evidenced the greatest symptomatic improvement (case 4).

Figure III. 6: Probabilities of Performing Change IMs



4.4 Are there significant differences in the probabilities of each theme occurring over time in cases with different symptomatic improvement?

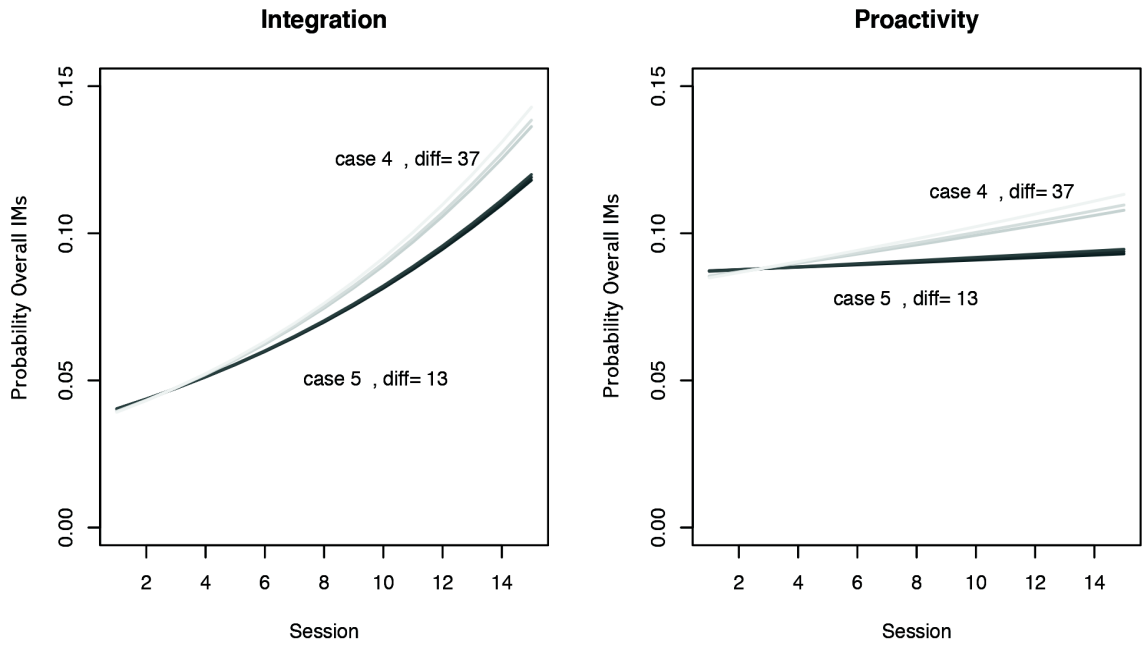
An exploratory analysis of the data showed that the most salient theme in the entire sample was "Proactivity" (38.8%), followed by "Integration" (33.1%) and "Others" (28.1%).

As previously described, "Proactivity" integrated all IMs associated with the clients' search for moments of well-being (e.g., going for a walk in the nearby city), which represented alternatives to the problematic story of loss. The theme "Integration", in turn, consisted of all IMs associated with the client's investment in new forms of connection with the lost person(s), creating a more positive and adaptive meaning for his or her loss. Finally, "Others" integrated other forms of narrative elaboration related to the experience of grief, such as "Self-forgiveness"

(3.9%, referring to the client's self-forgiveness regarding past decisions involving the lost ones), "Acceptance of death" (3.3%, referring to the client's assimilation of the notion of death as a universal experience that could be liberating to ill persons) and "New Investments" (8.8%, referring to the client's involvement in new projects, such as having a new job, as a consequence of change). The category "Others" also included the theme "Assertiveness" (12.1%), which was not directly related to the grief experience but with the adoption of assertive positions towards abusive relationships or active resolution of other interpersonal conflicts.

The probabilities of "Integration" and "Proactivity" considering the results for the overall IMs are illustrated in Figure 7.

Figure III. 7: Integration and Proactivity evolution in overall IMs



The highest probability of "Integration" occurring was approximately 14%, (last session of case 4, the case with the greatest grief symptomatic improvement). The highest probability of "Proactivity" occurring was approximately 12% (also during the last session of case 4). The GLM analysis showed that neither "Integration" (p = .45) nor "Proactivity" (p = .81) showed significant differences associated with the parameter "symptomatic improvement". However, both themes' probabilities were positively affected by the evolution of time (p < .0001) and by the interaction between time and symptomatic improvement (p < .0001). As depicted in Figure 7, the differences between cases regarding the elaboration of both themes

started to become more visible as the therapeutic process progressed, especially from session 6 onwards. In general, "Integration" was the theme in which the rate of IMs evolution over time was most evident, especially in the cases with greater symptomatic improvement (as depicted by the lighter grey lines in Figure 7).

5 DISCUSSION

Recent studies in psychotherapy have suggested the relevance of Innovative Moments (IMs) in the transformation of problematic self-narratives in therapy (Alves et al., 2012; Alves et al., in press; Gonçalves, Mendes et al., 2010; Matos et al., 2009; Mendes et al., 2010; Santos et al., 2009). In line with previous research, this study allowed us to explore how IMs are associated with self-transformation and symptomatic improvement in grief therapy. Our study also addressed how overall IMs were associated with themes identified in previous research as relevant narrative processes in grief adaptation (Alves et al., in press), such as loss integration (i.e., integration) and the search for moments of well-being and life reconstruction (i.e., proactivity).

In general, the results of this study show that IMs can be reliably identified in constructivist grief therapy, allowing for the study of how alternative meanings develop throughout successive sessions. The overall salience of the IMs in this sample was 22.9%, which is similar to the results found in other samples (e.g. EFT; Mendes et al., 2010).

Regarding the pattern of overall IMs, the results indicate that IMs emergence is significantly predicted by the evolution of time and by the interaction between time and symptomatic improvement. As presented above in Figure 2, despite the similar probability of IMs occurrence at baseline, the differences between the cases start to become significant as time progresses, especially from session 6 onwards. More specifically, the rate of IMs production increased faster as treatment progressed in cases with greater symptomatic improvement. This finding is consistent with previous research indicating a higher rate of IMs production over time in cases with greater clinical change, especially from the middle to the end of therapy (Gonçalves, Mendes, Cruz et al., 2012; Matos et al., 2009; Mendes et al., 2010). From our perspective, the higher rate of IMs production in more successful cases supports the

idea that narrative changes co-occurs with therapeutic change. In grief therapy, specifically, the decreasing of complicated grief symptomatology may reflect the person's new ability to make sense and integrate the experience of loss in a more flexible and adaptive way (Alves et al., in press; (Currier, Holland, Coleman, & Neimeyer, 2007; Keesee, Currier, & Neimeyer, 2008; Lichtenthal, Currier, Neimeyer, & Keesee, 2010; Neimeyer, Baldwin, & Gillies, 2006). In this sense, it seems that clients' progressive ability to invest in alternative experiences (IMs) and especially to integrate loss (Integration) and search for moments of well-being (Proactivity) is associated with more positive grief outcomes.

The IMs with the lowest probability of emergence in this sample were action, protest 1 and protest 2 (less than 1%). These results are consistent with the lower salience of these IMs in previous studies in constructivist grief therapy (Alves et al., in press; Alves et al., 2012). As suggested in both studies, the meaning reconstruction approach is much more oriented to the investment in new symbolic or representational ways of perceiving the loss and connecting with the lost person rather than through an emphasis on the expression of protest or behavioral processes to face the unwanted loss. In this sense, contrary to the presence of protest and action IMs observed in other samples (e.g. major depression, women victims of partner violence), where the client actively engaged in new behaviors and new positions of criticism towards the problem's demands, the focus of constructivist grief therapy relies on more meaning-making interventions focused on clients' efforts to make sense of their new realities of life (Neimeyer, 2001; 2006b; Neimeyer et al., 2010). The higher salience of reflection and reconceptualization IMs (both meaning-centered IMs) both in previous CGT studies (Alves et al., 2012; Alves et al., in press) as well as in this study supports this hypothesis.

Performing change IMs have a maximum probability of occurrence of approximately 3.5% in this sample. As shown above in Figure 6, the probability of this IM increases remarkably in the final part of therapy, and this increase is considerably more evident in cases with greater symptomatic improvement. The significant impact of the symptomatic improvement in performing change right from baseline – in contrast with the results for the other IMs – indicates that the elaboration of new projects and investments as a consequence of the change process (expressed through this IM) is more likely to happen in cases with less severe grief symptomatology. If we consider the hypothesis postulated by the heuristic model of

change, (Gonçalves et al., 2009) that performing change IMs represent clients' autonomous investment in a new life disconnected from the problematic self-narrative, this finding suggests that the elaboration of this specific IM in grief therapy is more likely to occur when the client is already capable of living his or her loss with lower levels of distress (that is, with less complicated grief symptomatology).

Reflection and reconceptualization were the most salient IMs in the entire sample, especially reflection IMs, representing 17.5% of the text coded as IMs (divided almost equally among subtype 1 at 9.2% and subtype 2 at 8.3%). However, while the probability of reflection 1 decreased gradually over time, reflection 2 increased gradually from the beginning until the end of treatment, especially in cases with higher symptomatic improvement. These results indicate that, as the therapeutic process progressed, clients moved from elaboration of intentions to surpass the difficulties of complicated grief (reflection 1) to the elaboration of new meanings and self-positions associated with a new and more flexible grief experience (reflection 2). These results are consistent with previous studies suggesting that the evolution from reflection 1 to reflection 2 is an important movement in the change process, depicting the client's progression from the exploration and acknowledgement of the problems' rules toward the adoption of new self versions to deal with the problem (Mendes, Ribeiro, Angus, Greenberg, & Gonçalves, 2011), which also occurred in this sample.

Reconceptualization is the IM that reached the maximum probability of occurrence (25% in the last session of case 4, as presented in Figure 5). As presented above, there is no significant effect of symptomatic improvement in reconceptualization probability. However, there is a significant impact of the way this IM is elaborated over time if we consider cases with different levels of clinical improvement. As illustrated in Figure 5, the probability of reconceptualization occurring is almost zero until the middle of therapy in all cases, and then it increases from session 6 onwards, especially in cases with greater symptomatic improvement. That is, cases with greater clinical change present a higher rate of reconceptualization production compared with cases with lower clinical change, which is more evident in the last sessions. This result seems to corroborate previous research suggesting the centrality of reconceptualization specially in later phases of successful therapy (Gonçalves et al., 2009), stressing out the different profiles of IMs' evolutions among cases with different clinical progressions.

One of the main limitations of this study is the size of the sample, which constrains any attempt to generalize the conclusions to other complicated grief cases. However, we believe that this study demonstrates the applicability of IMCS to different samples than those studied before, supporting, at least partially, the heuristic model of change proposed by Gonçalves et al., (2009). Another limitation is the fact that the theme-coding procedure for 50% of the sample was coded by only one coder, which may limit the reliability of the results. Additionally, all clients in this sample were followed by only one therapist in a non-manual intervention, which restricts data generalization.

Despite the limitations presented above, this study may provide important information regarding the narrative processes involved in grief therapy and how these narrative constructions impact complicated grief recovery.

6 FUTURE RESEARCH

Different therapists and therapeutic modalities should be considered in future research. The exploration of therapists' involvement in IM elaboration would also be relevant. For example, studying how different IMs are initiated by the client or by the therapist may have an impact in the meaning-reconstruction activity in grief therapy and how it may influence the magnitude of symptomatic improvement.

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CHAPTER IV

AMBIVALENCE IN GRIEF THERAPY: THE OSCILLATION BETWEEN CHANGE AND THE RE-EMERGENCE OF THE PROBLEMATIC NARRATIVE OF LOSS

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AMBIVALENCE IN GRIEF THERAPY: THE OSCILLATION BETWEEN CHANGE AND THE RE-EMERGENCE OF THE PROBLEMATIC NARRATIVE OF LOSS[7]

1 ABSTRACT

This paper explores the role of ambivalence in constructivist grief therapy within a narrative framework. From this perspective, the change process starts with the emergence of alternative experiences to the problematic self-narrative (Innovative Moments) that can be expanded until a new, more adaptive self-narrative emerges. However, when an Innovative Moment (IM) emerges, change can be attenuated if the client continues to emphasize the problematic self-narrative. This attenuation is a sign of ambivalence. This study aims to analyze markers of ambivalence in six complicated grief cases undergoing constructivist grief therapy. A total of 83 sessions, corresponding to a total number of 3293 IMs, were analyzed using the "Return to the Problem Coding System" (RPCS). The RPCS is an empirical system that tracks every time an IM is attenuated by a return to the problematic self-narrative. To assess grief symptomatology, clients completed the Inventory of Complicated Grief. The results showed that returns to a problematic self-narrative emerged in all cases. A generalized linear model analysis (GLM) showed that the probability of these returns decreased over time in cases with greater symptomatic improvement; the opposite occurred in cases with less improvement. These results suggest an association between symptom improvement and reduced ambivalence, supporting previously reported findings.

[7] This study was submitted to the jounal *Psychotherapy* with the following authors: D. Alves, P. Fernández-Navarro, A.P. Ribeiro, E. Ribeiro, I. Sousa, & M. M. Gonçalves.

2 INTRODUCTION

The framework of analysis used in this study is based on the *narrative metaphor* (Sarbin, 1986), which highlights humans' capacity to address the diversity of life experiences by organizing them into coherent stories or self-narratives that are shared with others (Angus & McLeod, 2004; Bruner, 1990; Hermans & Hermans-Jansen, 1995; McAdams, 1993; Polkinghorne, 1988; White, 2007; White & Epston, 1990). Consistent with this narrative background, Gonçalves, Matos and Santos (2009) suggest that change in psychotherapy occurs as clients transform their previous problematic self-narratives by elaborating on alternative experiences called "Innovative Moments" (IMs). From this perspective, problematic self-narratives can be conceived as implicit rules that organize the self (e.g., "*I should never express my feelings*"), while IMs represent the exceptions to these rules (Gonçalves, Santos et al., 2010).

To study the emergence of IMs, Gonçalves and collaborators (Gonçalves, Ribeiro, Mendes, Matos, & Santos, 2011) constructed the "Innovative Moments Coding System" (IMCS) that defines five types of IMs (action, reflection, protest, reconceptualization and performing change). The IMCS also proposes the subdivision of the reflection and protest IMs in subtypes 1 and 2, as presented in Table 1.

Table IV. 1: Innovative Moments with examples (Problematic self-narrative: Complicated Grief)

	Contents	Examples
Action	• New coping behaviors facing anticipated or existent obstacles; • Effective resolution of unsolved problem(s); • Active exploration of solutions; • Restoring autonomy and self-control; • Searching for information about the problem(s).	*C: Yesterday I woke up feeling very sad about her loss, but instead of staying in my bed crying all day, I took a ride to the city, visited the church to ask God to help me organize my life.*

Reflection	***Subtype I. Creating distance from the problem(s)*** • Comprehension – Reconsidering causes of problem(s) and/or awareness of its / their effects; • Formulation of new problem(s); • Adaptive self-instructions and thoughts; • Intention to fight demands of problems, references of self-worth and/or feelings of well-being.	*C: I want to live my life in a different way, trying to remember the things my daughter taught me. I'm sure she would say to me "keep going mom, you're on the right track".*
	Subtype II. Centered on the change • Therapeutic Process – Reflecting about the therapeutic process; • Change Process – Considering the process and strategies implemented to overcome the problem(s); references of self-worth and/or feelings of well-being (as consequences of change); • New positions – references to new/emergent identity versions in face of the problem(s).	*C: our sessions are helping me to accept this situation (the daughter's loss) in a more peaceful way because now I know that I have the strength to do this.*
Protest	***Criticizing the problem(s)*** • Repositioning oneself towards the problem(s).	*C I'm tired of not having the right to cry and talk about my feelings and my sadness in front of others! It has to change!!*
	Emergence of new positions • Positions of assertiveness and empowerment;	*C: I will not wear black clothes everyday just to show others that's I'm grieving! Not anymore! Now I don't care, I wear what I want and no one has nothing to do with it!*
Reconceptualization	Reconceptualization always involves two dimensions: • Description of the shift between two positions (past and present); • The process underlying this transformation.	*C: Let's think, for example, about the Mayan pyramids I climbed a few years ago. At the beginning I was stuck at the middle of the pyramid…However, then I realized that I couldn't be on that position forever, so I found a more stable spot…and started to get down slowly. Here (in therapy) it was the same, I didn't know how to address her loss and I learned gradually how to accept and (…) how to "go down" slowly into the ground (…) For example I started to give much more value to spiritual rather than physical things, and even if I lost a really beautiful daughter (physically), her actions and the way she helped persons were even much more beautiful (…)She's present in a different way.*
Performing Chang	• Generalization into the future and other life dimensions of good outcomes; • Problematic experience as a resource in new situations; • Investment in new projects as a result of the process of change; • Investment in new relationships as a result of the process of change; • Performance of change: new skills; • Re-emergence of neglected or forgotten self-versions.	*C: Now I can feel her presence in my life in a different way, not in her house, in her clothes, or even at the cemetery. Now I feel her presence in my thoughts, in my new life, and I know that she is protecting me, and all my decisions to organize my life count with her strength. In the last week I started to plant new flowers on my backyard. I'm investing in "life" again, seeing these flowers growing every day because of me. She (the daughter) would be very proud of me!*

In general, studies using the IMCS in different therapeutic modalities (e.g.,

narrative therapy, client-centered therapy, emotion-focused therapy) showed that good outcome cases present a greater number of IMs and higher diversity of IM types throughout treatment when compared to poor outcome cases (Gonçalves, Matos et al., 2009; Gonçalves, Mendes, Cruz, Ribeiro, Angus, & Greenberg, 2012; Matos, Santos, Gonçalves, & Martins, 2009; Ribeiro, Bento, Salgado, Stiles, & Gonçalves, 2011; Santos, Gonçalves, Matos, & Salvatore, 2009). Considering the main results of these studies, Gonçalves and collaborators (Gonçalves, Matos et. al, 2009; Matos et. al, 2009) proposed a heuristic model of narrative change in brief psychotherapy. According to this model, change starts with the emergence of action, reflection and protest IMs, as the client searches for new ways of acting, feeling and thinking that differ from the problematic self-narrative. Although these IMs are necessary for the change process to unfold, they are also insufficient for the development of a consistent alternative self-narrative (Gonçalves, Matos et al., 2009). Reconceptualization, in contrast, plays a central role in the change process. This IM has two main features: it presents a contrast between past problematic self and emerging alternative narratives, and it describes the process allowing this transformation. In this sense, this IM allows a sense of authorship because the client not only understands what is different in him or herself, but also recognizes the processes involved in the transformation (Gonçalves, Matos et al., 2009; Gonçalves & Ribeiro, 2012). Reconceptualization usually emerges in the middle phase of therapy and increases in presence until termination. Finally, performing change IMs tend to emerge after the recurrence of reconceptualization; this involves investing in new projects and performing new skills as a consequence of the change process.

2.1 Ambivalence in psychotherapy

In addition of studying clients' self-narrative transformation in therapy, recent research using the Innovative Moments Coding System (IMCS) has shown that in both poor-outcome cases (Santos, Gonçalves, & Matos, 2010) and the initial and middle phases of good-outcome cases (Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro & Gonçalves, 2011), clients tend to attenuate the potential for change presented by IMs. According to Ribeiro and Gonçalves (2010), the emergence of IMs – as new episodes in clients' lives – can be felt as unfamiliar experiences that

challenge the stability of the former problematic self-narrative. In some cases, this prompts a response of ambivalence (Engle & Arkowitz, 2008). In this sense, after the emergence of an IM, clients may emphasize again the dominance of the problematic self-narrative to reduce discrepancy produced by the innovation (Gonçalves, Ribeiro, Stiles et al., 2011). The following excerpt of a client's speech is an example of this process: *"I want to change my life, to start something new* [reflection IM], *but every time I try it I see how impossible it is* [attenuation of the change potential of the former IM]". In this example, the client invests in the elaboration of an IM, but as the innovation challenges his or her stable yet problematic self-narrative, it is quickly attenuated by what Gonçalves, Ribeiro, Stiles et al. (2011) termed a "return to the problematic self-narrative."

Gonçalves, Ribeiro, Stiles et al. (2011) proposed that the identification of moments in which clients return to the problematic self-narrative following the elaboration of an IM is an empirical indicator of ambivalence in psychotherapy. For this purpose, they developed the "Return to the Problem Coding System" (RPCS; Gonçalves, Ribeiro, Santos, J. Gonçalves, & Conde, 2009). In the RPCS, every IM that emerges during therapy is coded regarding the presence or absence of a "return to the problem marker" (RPM). In a pilot study using the RPCS in narrative therapy (NT) with female victims of intimate violence, Gonçalves, Ribeiro, Stiles et al. (2011) found that poor-outcome cases presented a significantly higher proportion of IMs followed by RPMs than good outcome cases. In contrast, a more recent study of emotion-focused therapy (EFT) for depression (Ribeiro, Mendes, Stiles, Sousa, & Gonçalves, 2012) showed that both good and poor-outcome groups presented similar overall proportions of IMs followed by RPMs, suggesting that ambivalence may be a natural phenomenon in the change process (Mahoney, 2003), associated with clients' self-protection from the anxiety generated by change (Engle & Holiman, 2002). Despite similar proportions of RPMs in the study of Ribeiro, Mendes et al. (2012), good and poor outcome cases presented different trajectories of RPMs over time: whereas RPMs decreased gradually in the good-outcome group, they remained considerably high until termination in the poor outcome group. According to the authors, the results of the good outcome group may be associated with the clients' (new) ability to re-integrate the problematic experiences in a new and more flexible self-narrative, whereas poor outcome cases may sustain the elaboration of RPMs as an indicator of the remaining conflicts between the old and the new self-narratives.

Finally, the study of Ribeiro, Mendes et al. (2012) also showed that the probability of RPMs decreased in sessions in which there was greater diversity of IMs type (4 or more types) when compared to sessions with less IM diversity (3 or less types); it occurred both in good and poor outcome cases. This result appears to be consistent with the assumption made by Gonçalves, Matos et al. (2009) that highlights investment in several different kinds of IMs as a central mechanism in the development of a coherent and flexible change process. In this line of reasoning, a self-narrative associated with lower IM type diversity could be associated with a more inflexible (and monotonous) story; this may facilitate IM attenuation by the emergence of RPMs.

2.2 Ambivalence in constructivist grief therapy

The results of an exploratory study (Alves, Fernández-Navarro, Ribeiro, Ribeiro, & Gonçalves, in press) of two complicated grief cases (one recovered case and one improved but not recovered case) showed that the progression of IMs and RPMs was significantly correlated in both cases (.75 and .79, p = .001). These cross-correlations were considerably higher when compared, for example, to the cross-correlational values obtained in the EFT study (.39, p = < .001) from Ribeiro, Mendes, et al. (2012). Considering these results, Alves, et al., (in press) suggested that some clients may perceive their change as a "disconnection" from the lost loved one(s), thus producing RPMs as a movement of self-protection from the anxiety or guilt produced by this interpretation. To illustrate this movement of self-protection associated with the re-emergence of the problematic story of loss, let's consider an example of an IM followed by a RPM in a complicated grief case of a mother that was reflecting on the way she felt in her first anniversary without her son (which she had anticipated as a very painful day): "*Unexpectedly I felt so good during my anniversary* (reflection IM) *that I even felt angry with myself* (RPM)". In this example, the client started to invest in the description of a more positive and less painful experience but she immediately attenuated the potential for change involved in that experience by reinforcing the problematic self-narrative. Reinforcing this problematic narrative of loss may have allowed her to maintain this connection and to avoid the guilt of releasing the intense pain as an abandonment of her son.

2.3 The present study

This study explores the role of ambivalence in constructivist grief therapy by shedding light on how the problematic story of loss can be maintained by returning to the problematic self-narrative after the elaboration of an IM. A sample of six complicated grief clients – previously analyzed using the Innovative Moments Coding System (IMCS; Alves et al., 2012) – was studied considering the production of RPMs. Clients symptomatic change was assessed with the Inventory of Complicated Grief (Prigerson et al., 1995).

In general, we anticipate that all cases included in this sample will present RPMs, associated with a response of self-protection (Engle & Holiman, 2002) after the elaboration of IMs. We also anticipate that the probability of IMs containing RPMs will decrease more in cases with greater symptomatic improvement than in cases with lower symptomatic improvement. Finally, we expect that action, reflection and protest IMs (more elementary forms of innovation) will be more likely to be attenuated by RPMs than reconceptualization and performing change, which are more complex IMs typically associated with later phases of successful change (Gonçalves, Matos et al., 2009).

Thus, the main research questions of this study are as follows:

1. Do all cases in the study present RPMs?
2. Are there significant differences in the probabilities of RPMs occurring over time among cases with different grief symptomatic improvement?
3. Are there significant differences in the occurrence of RPMs following different types of IMs?
4. Given that greater IM diversity has been previously associated with lower levels of RPMs, are there significant differences in the occurrence of RPMs in sessions with higher or lower IM diversity?

3 METHOD

The data used in this study were drawn from Alves et al. (2012) study of IMs in constructivist grief therapy. A total of 83 sessions (all sessions of the 6 cases previously analyzed with the IMCS) were examined using the Return to the Problem Coding System (RPCS) for the present study. From these 6 cases, a sample of 3293

IMs was analyzed for the presence of RPMs. The methodology and procedures are described below.

3.1 Clients

Clients were recruited from a research program investigating narrative change in psychotherapy, designed to explore the processes of change in different therapeutic samples. Each client who was recruited for this study was followed weekly in individual constructivist grief therapy (Neimeyer, 2001; 2006). The treatment protocol was shared with the client at the pre-therapy assessment meeting, and it was established according to the guidelines of a clinical trial that proposed 15 sessions of treatment (clients could be referred for further treatment after 15 sessions, if necessary). All sessions were video recorded and transcribed; all clients gave permission for their materials to be used in the study. The ethical committee of the local hospital (the institution referring clients for treatment) also approved this protocol.

Six clients evaluated with complicated grief (Prigerson et al., 1995) were analyzed in this study. All clients were Caucasian women aged 20-62 years (M = 42 years, SD = 18.63) and completed an average of 13.83 sessions (SD = 0.98). The analysis of pre to post-symptomatic change in complicated grief was based on the Inventory of Complicated Grief (ICG; Prigerson et al., 1995; Portuguese version by Frade et al., 2009).

At the pre-therapy assessment meeting, clients presented the following circumstances of loss: loss of a grandmother to a stroke three years prior to therapy (case 1); loss of a boyfriend to cancer two years prior to therapy (case 2); loss of a husband to cancer two years prior to therapy (case 3); loss of a daughter to cancer two years prior to therapy (case 4); loss of a son to cancer three years prior to therapy and loss of a husband who was run over by a car six months prior to therapy (case 5); and loss of a mother to stroke one year prior to therapy (case 6). Two clients maintained stressful relationships with other family members (e.g., economic and marital problems) that, despite not being as central as the complicated grief, were noted in their therapy.

3.2 Therapist and therapy

The therapist for all 6 cases was a 26-year-old doctoral student with three years of prior clinical experience as a psychotherapist and two years of experience in constructivist psychotherapy with grief clients. A skilled therapist with 18 years of experience in constructivist psychotherapy supervised the clinical practice to ensure adherence to the constructivist model.

Constructivist grief therapy (CGT) was conducted according to the meaning reconstruction approach proposed by Neimeyer (2001, 2006). It was initiated with the exploration of each client's grief experience using the "Meaning Reconstruction Interview" (Neimeyer, 2006, pp.166-169). The global treatment protocol did not follow a manualized structure; it was designed according the constructivist approach that promotes client self-reconstruction through investment in alternative, more adaptive meanings of loss (Neimeyer, 2001; 2006; Neimeyer, Burke, Mackay and van Dyke-Stringer, 2010). Several narrative-constructivist activities were used, including "narrative retelling" (Neimeyer et al., 2010, p.76; Neimeyer, 2012), "imaginal conversations with the deceased" (Shear, Boelen, & Neimeyer, 2011, p.149) and "unsent letters" (Neimeyer, 2006, pp.196-199).

3.3 Researchers

Two judges were involved in the RPM coding process of this sample. Judge 1 coded the RPMs of all six cases (corresponding to a total of 83 sessions) and judge 2 coded the RPMs in three cases. Both judges were doctoral students of clinical psychology with experience in IMs and RPMs coding procedures. A third researcher, also a doctoral student of clinical psychology and skilled researcher in RPMs coding, audited analyses of each session using the RPCS.

3.4 Measures

3.4.1 Outcome measures

Structured Clinical Interviews for DSM-IV-TR, *Axis I* (SCID-I; First, Spitzer, Gibbons, & Williams, 2002) and *Axis II* (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). SCID-I and SCID-II are based in DSM-IV-TR diagnostic criteria and allow for the assessment of clients' disorders on axis I (mood,

psychotic and anxiety disorders) and axis II (personality disorders). Inter-rater reliability ranged from .83 to .85 for the SCID-I (Del-Ben et al., 2001) and .63 for the SCID-II (Weertman, Arntz, Dreessen, Velzen, & Vertommen, 2003).

Inventory of Complicated Grief (ICG; Prigerson et al., 1995). The ICG is a 19-item questionnaire that assesses the severity of grief symptoms. The items are rated on a 5-point Likert scale, from 0 ("never") to 4 ("always"), with total scores ranging from 0 to 76. A score above 25 after at least 6 months after loss suggests complicated grief. The instrument has good internal consistency (.94; Prigerson et al., 1995). We used the Portuguese adaptation by Frade, Pacheco, Sousa, and Rocha (2009), which also has good internal consistency (.91; Frade et al., 2009). The cut-off score for the Portuguese population was 30 (Sousa & Rocha, 2011). The internal consistency of the ICG in the present study was .84.

3.4.2 Process Measures

Return to the Problem Coding System (RPCS; Gonçalves, Ribeiro, Santos, J. Gonçalves, & Conde, 2009). The RPCS is a qualitative coding system that analyzes the re-emergence of the problematic self-narrative through the identification of RPMs occurring immediately after the emergence of an IM. Previous studies using the RPCS (Gonçalves, Ribeiro, Stiles et al., 2011; Ribeiro, Cruz, et al., 2012; Ribeiro, Mendes, et al., 2012) have reported reliable agreement between judges on RPM coding and a Cohen's kappa between .88 and .93.

3.5 Procedures

Outcome measures

To assess co-morbidity with other diagnoses that could be more relevant than complicated grief, all clients were evaluated with the SCID-I (First et al., 2002) and SCID-II (First et al., 1997) in the pre-therapy assessment meeting. To specifically assess complicated grief symptomatology, the Portuguese version of the ICG (Frade et al., 2009) was administered. The ICG was then administered every fourth session as well as in the final session and at the 6-month post-termination follow-up meeting.

According to the clinical criteria proposed by Prigerson and collaborators (1995), all six clients included in this study were diagnosed with complicated grief during the assessment meeting. Five clients also showed comorbid major depression

as defined by the DSM-IV (American Psychiatric Association, 1994). Considering the established cut-off score of 30 for the Portuguese version of the ICG (Sousa & Rocha, 2011), four cases (cases 1, 2, 3 and 4) experienced substantial changes in complicated grief symptoms: final ICG scores were lower than 30 in these cases. In contrast, two cases (cases 5 and 6) did not show a significant clinical change in complicated grief symptomatology by the end of treatment.

Process measures

Return to the Problem Coding System (RPCS): RPMs training, coding and reliability

As previously stated, 2 judges were involved in the coding process using the RPCS. Judge 1 analyzed all IMs of this sample (previously coded with the IMCS) to determine the re-emergence of the problematic self-narrative (i.e. RPM). The coding of the 3 cases by judges 1 and 2 involved two successive steps: a) independent coding, and b) resolution of disagreements by consensus. Therefore, both judges first independently coded all sessions' transcripts and subsequently discussed final coding decisions. Reliability between judges 1 and 2, as assessed by Cohen's kappa, was .85. An external auditor was involved in the final coding decision; he reviewed coding disagreements and the final RPM coding decisions. Judge 2 and the auditor were blind as to the clinical outcome of each case.

4 RESULTS

4.1 The emergence of RPMs in cases with different symptomatic improvements

All the analyses presented bellow considered the percentage of IMs with RPMs (frequency of IMs with RPMs/total frequency of IMs x 100), rather than the direct frequency of RPMs.

As we anticipated, every case presented IMs with RPMs. The mean overall percentage of RPMs for the entire sample was 21.5%. Previous studies in other samples have reported overall percentages of RPMs between 20% and 40% (Ribeiro, Cruz, et al., 2012; Ribeiro, Mendes, et al., 2012). As shown in Table 2, case 5 (the case with the lowest symptomatic improvement in the ICG) showed the greatest

percentage of RPMs (24.5% of the total RPMs of the entire sample). Cases 1 and 3 (whose symptomatic improvements were among the greatest for the entire sample) showed the lowest percentage of RPMs (11.2%).

Table IV. 2: Cases' ICG pre-post scores (cut-off score 30), total percentages of RPMs and cross-correlations, at lag 0, between IMs and RPMs

Case	Pre-test ICG	Post-test ICG	Symptomatic improvement in the ICG	Total percentage of RPMs	Spearman cross-correlation IMs x RPMs
1	42	11	31	11.2%	$r = .75$, $p = .001$
2	39	25	14	23.8%	$r = .64$, $p = .003$
3	61	28	33	11.2%	$r = .48$, $p = .037$
4	58	21	**37**	16.5%	$r = .14$, $p = .332$
5	55	42	13	**24.5%**	$\mathbf{r = .79, p = .001}$
6	51	36	15	12.8%	$r = .27$, $p = .186$

Simulation Modeling Analysis (SMA; Borckardt et al., 2008) – a method for assessing the statistical significance of sequential observations in a data series – was performed in order to explore Spearman cross-correlations between IMs and RPMs in each case with the Bonferroni correction. The results of the SMA showed that there was high variability between cases regarding the way IMs and RPMs were correlated; this was not necessarily determined by the magnitude of symptomatic improvement. As presented in Table 2, the case with the greatest association between IMs and RPMs was case 5 ($r = .79$, $p = .001$), one of the cases with the lowest symptomatic improvement in the ICG (13 points). The second greatest association between IMs and RPMs was demonstrated in case 1 ($r = .75$, $p = .001$), whose symptomatic improvement was among the greatest for the entire sample (31 points), as documented in the pre-post ICG evolution. Despite similar results of associations between IMs and RPMs, these cases exhibited very distinct stories of loss (loss of a grandmother to stroke and loss of husband and son, to car accident and cancer, respectively) and very different ways of integrating loss in more symbolic and adaptive ways (for more information on the specifics of these two cases, see Alves et

al., in press). Finally, case 4 (loss of a daughter to cancer) presented the lowest association between IMs and RPMs (r = .14, p = .332); this case also exhibited the greatest symptomatic improvement (37 points). This client gradually progressed from a story of loss that was punctuated by confusion regarding God's decision to take her daughter's life to a more adaptive meaning centered on how God chose her daughter to protect her from a difficult life.

4.2 The evolution of RPMs over time in cases with differing symptomatic improvements

Similar to the study design proposed by Ribeiro, Mendes, et al., (2012), the data of this study have been modeled using a Generalized Linear Model (GLM; McCullagh & Nelder, 1989) to explore the probabilities of RPMs occurring among cases with differing symptomatic improvement over time. Using the GLM, a regression model of the probabilities was described as a linear function of the explanatory variables; outcomes varied between 0 and 1 (McCullagh & Nelder, 1989). Significance levels were established at α = .05. This method of analysis allowed all sessions to be included in the model, which is an advantage over more traditional regression analysis.

An integrated binomial model of the GLM analysis was used, assuming a linking function between the probability of IMs containing RPMs and the linear predictor. More specifically, considering p = probability of RPM, then:

$$p = \exp\frac{\exp(linearpredictors)}{1+\exp(linearpredictors)} = \frac{\exp\,(X\beta)}{1+\exp\,(X\beta)}$$

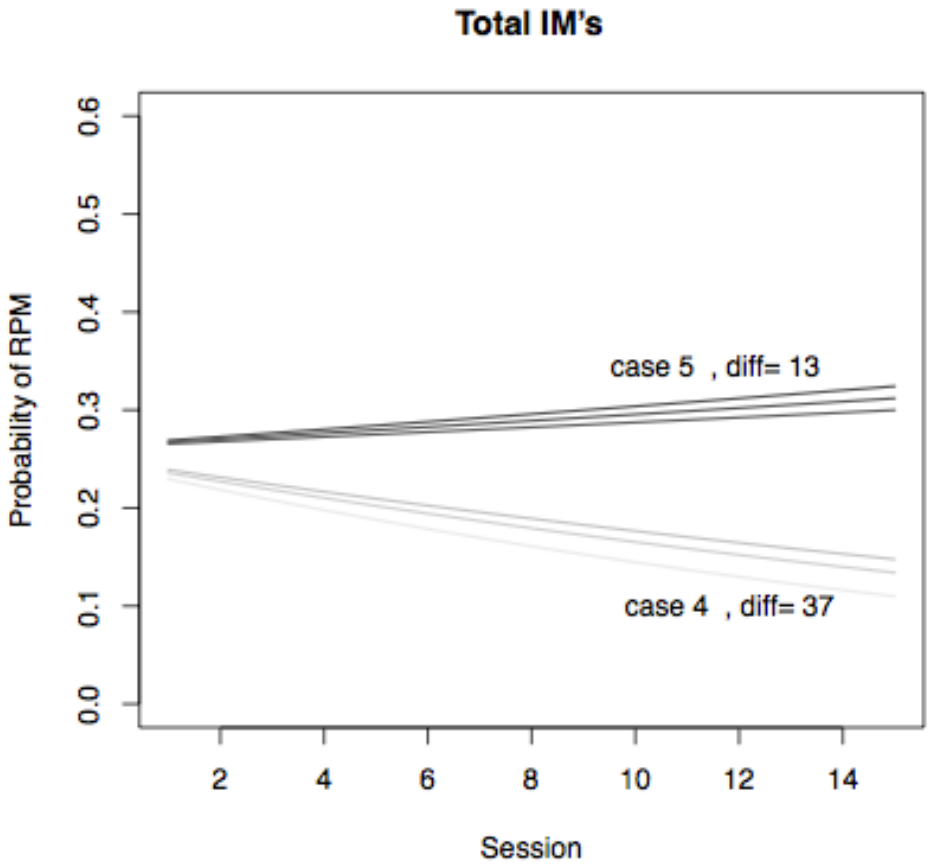
For the linear predictor, we used a linear function of the explanatory variables as:

$$linear\ predictor = X\times\beta$$

The proportion of RPMs was considered the response variable and "time" along treatment (from sessions 1 to 14), the "grief symptomatic improvement" (ICG pre therapy – ICG post therapy) and the "interaction between time and grief symptomatic improvement" were considered as explanatory variables.

The results for RPMs probabilities in overall IMs are illustrated in Figure 1.

Figure IV. 1: Probabilities of RPMs in overall IMs



The *Y*-axis depicts the probability of an RPM occurrence, and the *X*-axis depicts the evolution of therapy (session number) over time. Cases with different symptomatic improvements are illustrated by varying line color gradients. Lighter grey lines represent cases with the greatest pre-post symptomatic improvement on the ICG (the lighter line at the bottom of Figure 1, for example, depicts the results from case 4; this was the case with the greatest pre-post difference (37) in the ICG). Darker grey lines, in turn, represent cases with lower symptomatic improvement (the line at the top of Figure 1 depicts the results from case 5; this was the case with the lowest pre-post difference (13) in the ICG). The other grey lines appearing between these extremes represent the 4 remaining cases. The representations of these distinct grey lines are consistent throughout all figures presented in this paper[8].

[8] Note: Only the cases with extreme pre-post differences in the Inventory of Complicated Grief (4 and 5) are labeled in the figures.

The GLM analysis for RPM probabilities in the overall IMs showed that the variable "symptomatic improvement" had no significant effect on RPM production (p = .807). In contrast, the variables "time" (p = .012) and "interaction between time and symptomatic improvement" (p < .0001) had significant effects in the overall probability of RPM occurrence. This means that, at baseline, cases with different clinical outcomes did not differ significantly in terms of the production of RPMs. However, as therapy progressed, cases with differing symptomatic improvements became significantly different in terms of RPM production. More specifically, as presented in Figure 1, cases with greater change (illustrated by the lighter grey lines) experienced larger reductions in RPM production over time (progressing from approximately 24% to about 11%, considering the first and last sessions of case 4, the case with the highest grief symptomatic improvement). Cases with lower symptomatic change (illustrated by darker lines) experienced increased RPM production from the beginning to the end of therapy (progressing from 27% to 31% if we consider the first and last sessions of case 5, the case with the lowest grief symptomatic improvement).

4.3 The occurrence of RPMs in different types of IMs

The percentages of RPMs following each specific type of IM are presented in Table 3. In general, reflection 1 (14.2%) and reflection 2 (5.2%) were the IMs with the highest percentage of RPMs. The overall percentage of RPMs in other IM types was lower than 2.5%.

Table IV. 3: Total percentages of RPMs for each type of IM

Type of IM	Percentage of RPMs
Action	1.1%
Reflection 1	14.2%
Reflection 2	5.2%
Protest 1	0.2%
Protest 2	0.4%
Reconceptualization	0.2%
Performing Change	0.2%
Total	21.5%

The probability of IMs containing RPMs was then modeled using the GLM analysis. In particular the Binomial model was used, assuming a linking function between that probability and the linear predictor. That is, considering p = probability of RPM, then:

$$p = \frac{\exp(linearpredictors)}{1 + \exp(linearpredictors)} = \frac{\exp\,(X\beta)}{1 + \exp\,(X\beta)}$$

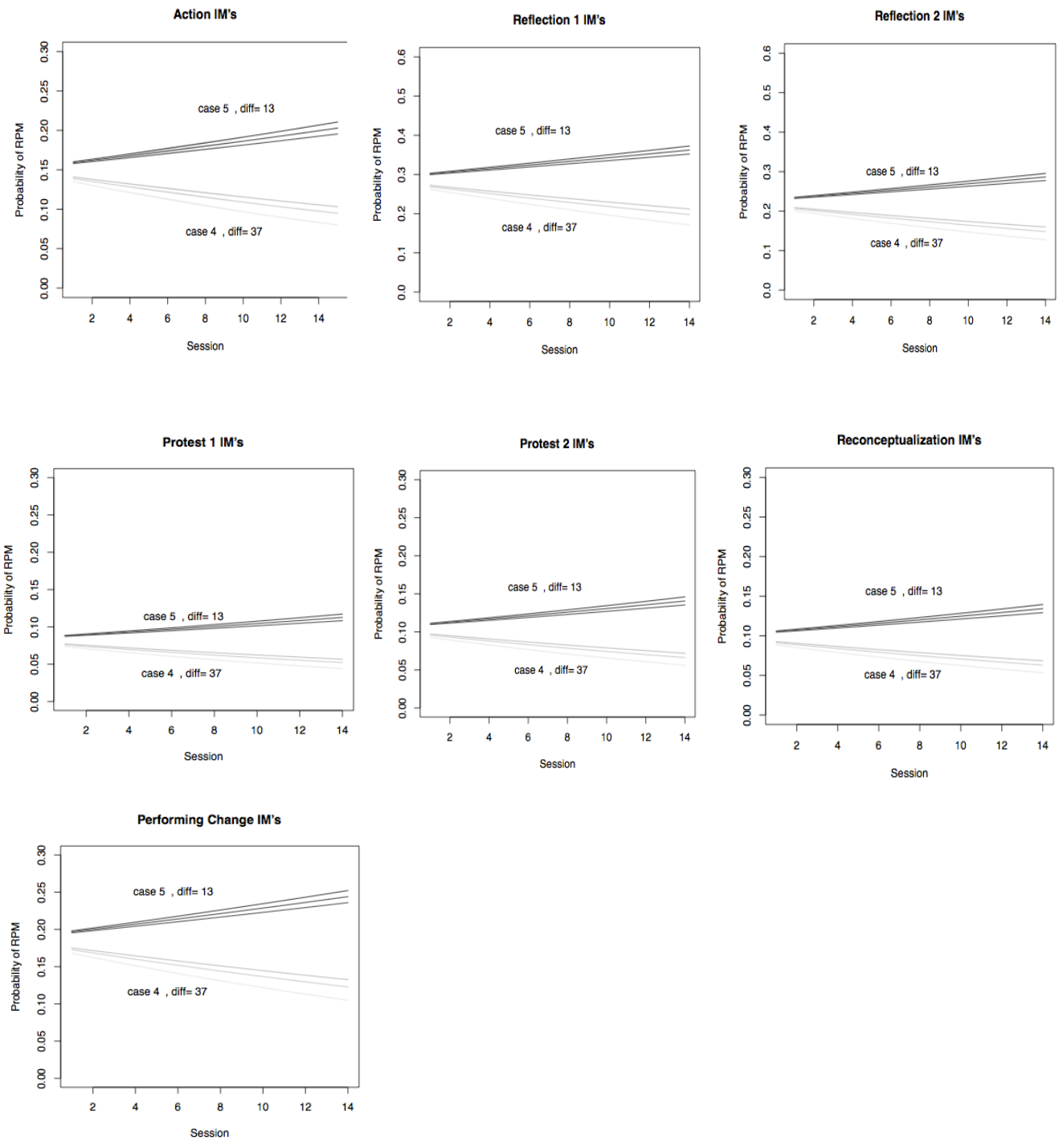
For the linear predictor, we used a linear function of the explanatory variables as:

$$linear\ predictor = X \times \beta$$

In this analysis, the proportion of RPMs was considered as the response variable and the "time" along treatment, the "grief symptomatic improvement", the "interaction between time and grief symptomatic improvement" and the "type of IM" were considered as the explanatory variables.

The results of the GLM analysis showed that reflection 1 ($p < .0001$) and reflection 2 ($p = .019$) presented significantly higher percentages of RPMs when compared to other IM types. The GLM analysis also showed that the variable "symptomatic improvement", at baseline, did not affect the occurrence of RPMs in different types of IMs ($p = .795$). In contrast, a significant impact of the variables "time" ($p = .020$) and "interaction between time and symptomatic improvement" ($p = .012$) was found. That is, differences between cases regarding RPM emergence in different IM types started to become significantly different as time progressed (as occurred in the results of RPMs in overall IMs). As presented in Figure 2, while cases with greatest clinical changes (the three cases illustrated by the lightest grey lines) experienced decreased probability of RPMs in all types of IMs, cases with lower clinical changes (the three cases illustrated by the darkest grey lines) experienced increased RPM probabilities over time, for all specific IMs.

Figure IV. 2: Probabilities of RPMs in action, reflection 1, reflection 2, protest 1, protest 2, reconceptualization and performing change IMs



4.4 The occurrence of RPMs in sessions with differing IM type diversity

A GLM analysis was performed to explore the occurrence of RPMs in sessions with differing IM type diversity. The proportion of RPMs was considered as the response variable and the "diversity of IM types" was considered as the explanatory variable. Two categories were created: 1) low diversity (1 to 3 types of IMs); and 2) high diversity (4 to 7 types of IMs). To explore the specific pattern of RPMs in sessions that included reconceptualization IMs (more complex IM associated with successful change), a third category was created. This category considers "6 or 7 types" of IMs (an exploratory analysis of the data showed that all sessions with 6 types of IMs included "reconceptualization").

The GLM analysis revealed that sessions with greater IM diversity (4 or more types) presented significantly lower probabilities of RPM occurrence than sessions with 1 to 3 types of IMs ($p = < .001$). Specifically, the probability of RPM occurrence decreased 38.9% in sessions with greater IM diversity. Sessions with 6 or 7 types of IMs also showed significantly reduced emergence of RPMs when compared to sessions with 1 to 3 types ($p = .018$), and even when compared to sessions with 4 and 5 types of IMs ($p = .011$).

5 DISCUSSION

In line with previous research using the Return to the Problem Coding System (RPCS; Gonçalves, Ribeiro, et al., 2009; Gonçalves, Ribeiro, Stiles, et al., 2011; Ribeiro, Cruz, et al., 2012; Ribeiro, Mendes, et al., 2012), this study allowed us to analyze how RPMs may be associated with client ambivalence to change via attenuation of the emergence of IMs during the therapeutic process.

In general, the results of this study show that RPMs can be reliably identified in constructivist grief therapy using the RPCS. The analysis of the 83 sessions using this coding system revealed that all cases presented RPMs; this finding was expected. This result appears to be consistent with the assumptions of several other authors who suggest that ambivalence is a normal aspect of the change process (Mahoney, 2003; Messer, 2002; Neimeyer, 1995), which is most likely associated with clients' self-protection regarding the anxiety of changing familiar ways of experiencing the world for new, unfamiliar ways (Engle & Holiman, 2002).

The results of this study regarding the cross-correlations between IMs and RPMs show a high heterogeneity in the way the six clients managed oscillations between change and the re-emergence of the problematic self-narrative over the course of therapy. We consider that these results highlight the importance of exploring clients' unique resources, vulnerabilities and expectations in order to deeper understand the meanings associated with their higher or lower investment in change or ambivalence, knowing that different persons may feel more or less confortable in living grief in a different way. For example, as suggested by Alves et al., (in press) some clients may invest in ambivalence as a way to protect themselves from the anxiety or guilt of perceiving themselves as "abandoning" the deceased by investing in a less painful grief experience. More studies with different cases are needed in order to further explore these hypotheses.

As we anticipated, cases with different symptomatic improvement showed different trajectories of RPM occurrence over time. Cases with lower symptomatic change progressed towards increasing elaboration of RPMs over time, while cases with higher symptomatic change showed the opposite effect: in these cases RPM probabilities decreased as therapy progressed over time. These results are consistent with the results of the EFT study (Ribeiro, Mendes, et al., 2012), in which a similar pattern was observed. We suggest that these results highlight differences between cases with varying clinical outcomes regarding clients' "timing" to reintegrate problems into a new self-narrative. It is possible that cases with lower clinical changes may need more time to give meaning to the uncertainty of change and to reintegrate unfamiliar experiences into a new self-narrative with lower levels of anxiety. Until this occurs, these cases may continue to elaborate RPMs to protect themselves from the challenges of self-transformation.

The results of this study also show that reflection 1 and reflection 2 have significant higher percentages of RPMs when compared to other IMs types. As suggested in previous research (Ribeiro, Cruz et al., 2012; Ribeiro, Mendes, et al., 2012), these forms of innovation – directly centered in altering the impact of the problem in client's life and reformulate its meaning– may create a context of meaning reconstruction in which the movement of self-protection (though RPMs) may be highly expressed (as these are the first attempts to try something different from the rules proposed by the problematic self-narrative). The exploratory analysis of the data also showed a higher percentage of RPMs after reflection 1 (14.2%) when

compared to reflection 2 (5.2%), which is also consistent with previous research (Ribeiro, Cruz et al., 2012; Ribeiro, Mendes, et al., 2012). We consider that the higher emergence of RPMs in reflection 1 may be related to the fact that this subtype is associated with the exploration of the problem and a new understanding of its domain in the client's life. Thus, as the client is operating to create a more clear contrast between the old and new self-narrative and exploring the emergence of new feelings and thoughts associated with the change process, these feelings may trigger anxiety and present the need to invest in RPMs elaboration.

This study also show that sessions with 4 or more types of IMs (high diversity) presented significantly less RPMs than sessions with low IM diversity (1 to 3 types), which is also consistent with the results from previous studies (Ribeiro, Mendes et al., 2012). This finding highlights the relevance of the elaboration and articulation of several different types of IMs to construct a consistent description of the change process (Gonçalves, Matos et al., 2009; Ribeiro, Mendes et al., 2012). In this line of reasoning, a new self-narrative elaborated upon low diversity of IMs types may represent a less rich story (Gonçalves, Matos et al., 2009; Ribeiro, Mendes et al., 2012), in which ambivalence is more prone to occur. The results also showed that when considering sessions with 6 or 7 types of IMs (which always included reconceptualization or reconceptualization and performing change – the two types of IMs that are associated with successful change), the emergence of RPMs was significantly lower when compared to sessions with 1 to 3 types (p = .018) or even 4 or 5 types (p = .011) of IMs. This result highlights, again, the relevance of IM diversity in the construction of stable change. More specifically, the emergence of reconceptualization in sessions in which other types of IMs also emerge may represent a privileged scenario to the development of a more stable change process characterized by lower levels of ambivalence. In this sense, we hypothesize that the anxiety associated with the emergence of unfamiliar meanings (IMs) may decrease as the client progresses toward a meta-understanding of the change process (reconceptualization) that connects the old and the new self- narratives (Cunha, Gonçalves, & Valsiner, 2011; Cunha, Gonçalves, Valsiner, Mendes, & Ribeiro, 2012; Gonçalves, Ribeiro, Stiles, et al., 2011; Santos & Gonçalves, 2009). In doing so, the client may start to feel as the principal author of this transformative progress, feeling less threatened by change and, consequently, less ambivalent (Cunha et al., 2011; Cunha et al., 2012).

6 LIMITATIONS AND FUTURE RESEARCH

The small size of the sample is one of the main limitations of this study. Further research using a larger sample of complicated grief cases and different therapeutic modalities is needed. Data generalization was prevented by the fact that only one therapist followed all cases using a non-manualized intervention.

Despite these limitations, we believe that this study has provided relevant information regarding the way complicated grief clients with different clinical outcomes address ambivalence in psychotherapy. It also sheds light onto how this may influence the processes of loss integration and the search for a less painful life after loss.

In the future, we think that it would be important to consider the effect of therapist participation in the way clients elaborate change (IMs) and ambivalence (through RPMs) within the interpersonal context created by both the client and therapist. We consider that the way this study was organized (focused only on clients' results) allowed us to study the intrapersonal component of ambivalence. However, it would be relevant to also explore the interpersonal aspects associated to the impact of the "therapeutic dialogue" in the way clients change over time, that is, how the therapist also contributes and deals with RPMs emergence and how different interventions may foster its increasing or decreasing. According to a recent study by A. Ribeiro, E. Ribeiro, et al., (2012), the emergence of RPMs (as an expression of client ambivalence) tends to occur when the client is confronted with challenging interventions that may be felt as less supportive and threatening. In this sense, the authors suggest adopting interventions that are less challenging and more empathetic, so that the client may feel that his/her problems and difficulties are carefully considered. Further research is needed regarding the association between therapist intervention and client investment in the elaboration of RPMs.

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CONCLUSION

CONCLUSION

"...the quest for meaning is the key to mental health and human flourishing''.

Frankl, 1992, p.157

In the last years, the concept of narrative has gained increasing importance in the fields of psychotherapy theory, research and practice, shedding light on the core psychological and social processes by which different persons give meaning to their worlds (Angus & McLeod, 2004; Gonçalves & Stiles, 2011). Regardless of the therapeutic model through which the intervention is based, there is a transversal interest on how the experience of therapy may contribute to the emergence of alternative and more inclusive ways of interpreting the reality (Angus & McLeod, 2004; Neimeyer & Bridges, 2003; Santos & Gonçalves, 2009). In the same framework, clients' difficulties are seen to reflect restricted and inflexible self-narratives that do not sufficiently integrate relevant aspects of their lives (Dimaggio, 2006; White & Epston, 1990).

Despite the significant body of literature indicating the relevance of narrative change in psychotherapy (e.g. Angus & McLeod, 2004; Bruner, 2004; McLeod & Balamoutsou, 1996; Neimeyer, 1995; Polkinghorne, 2004) there is little evidence about the specific processes by which clients' multiple narratives are articulated and integrated in therapy in order to potentiate change. As pointed out by Greenberg a few decades ago (1986), it is important to skip the gap between process and outcome research and orient our attention to the "clinically meaningful events" (p.4) that happen over the course of therapy and how they interact in order to foster therapeutic change. In the same line of reasoning, Elliott (2010) suggests the relevance of "an interpretative, theory-building framework" (p. 129) to analyze which therapeutic events (either productive and unproductive) are involved in the process of change, combining qualitative sequential descriptions of what happened across sessions and/or cases and connecting the "in-session processes" to post-therapy outcomes.

In line with the assumptions of Greenberg (1986) and Elliot (2010), this dissertation proposes the study of the specific processes that are available for self-narrative transformation or maintenance as therapy evolves. By exploring the emergence and development of IMs across sessions (sequential process design) in cases with different clinical improvements (quantitative-process outcome design), it conceptualizes how the emergence of particular events (e.g. thoughts, feelings and behaviors) places the client as an active negotiator of his or her own change *repertoire* (Gonçalves, Matos et al., 2009).

In the next lines I reflect on the main contributions offered by each of the previous chapters. I consider, especially, how the results of each study may provide relevant information about the transformative processes (IMs) and emerging themes (protonarratives) that are involved in self-narrative transformation in constructivist grief therapy, as well as the processes associated with clients' ambivalence (RPMs), which may help us understand the functions of their deliberate interruption of the change process by a "safe" return to the former problematic self-narrative. Thus, the present conclusion is organized around three major topics: 1) the pattern of innovative moments in constructivist grief therapy, 2) protonarratives in constructivist grief therapy and 3) ambivalence in constructivist grief therapy: the re-emergence of the problematic story of loss. Finally, I conclude with a general consideration of future research developments.

1 NARRATIVE CHANGE AND AMBIVALENCE IN CONSTRUCTIVIST GRIEF THERAPY THROUGH THE LENS OF THE INNOVATIVE MOMENTS MODEL

1.1 Addressing the pattern of innovative moments in constructivist grief therapy

This dissertation presents the first systematic effort to empirically explore the process of narrative change in constructivist grief therapy (CGT) through the

identification of innovative moments (IMs). In line with the theoretical background suggesting the relevance of meaning making interventions in grief therapy (Lichtenthal & Cruess 2010; Neimeyer et al., 2010), this research work was planned as an attempt to respond to the question "how do clients progress from the maintenance of a problematic story of loss toward a new and more flexible one throughout therapy?"

The case-study of Cara, presented in chapter I, was the first one addressing this question, by exploring all alternative details (IMs) that emerged in therapy and its association with meaning reconstruction over the 6 sessions of treatment. One of the main results of this study was the applicability of the Innovative Moments Coding System (IMCS) to study narrative change in CGT, presenting a pattern of IMs globally similar to those found in previous studies with different problems or diagnosis and therapeutic models (Gonçalves, Mendes et al., 2010; Matos et al., 2009; Mendes et al., 2010). As occurred in previous studies, reflection IMs appeared as the central type of innovation throughout the process, supporting the elaboration of other novel developments. The emergence of reconceptualization at the middle stage of therapy and performing change in the final phase of therapy (after reconceptualization) was also found in this first study, endorsing, again, the hypothesis proposed by the heuristic model of change (Gonçalves, Matos et al., 2009), regarding the pattern of IMs in successful change. The almost absence of protest IMs throughout the entire therapeutic work, in turn, was a marked difference regarding the results from previous studies. Especially in narrative therapy (Matos et al., 2009) and emotion-focused therapy (Mendes et al., 2010), this IM appeared as a relevant ingredient in the establishment of a new self-narrative, associated with clients' investment in a position of criticism and assertiveness towards the problem's demands. However, in CGT – mostly associated with the development of new ways of understanding, accepting and integrating the death of the loved one – the investment in a position of criticism directed towards the demands imposed by loss may not be relevant, as the reality of death is so incontrovertible that protest, per se, may intensify clients' sense of hopelessness. However, it is important to note that in other instances, protest IMs can involve the assertion of personal needs and rights in interpersonal or familiar relationships, as occurred in the studies with the Portuguese sample, which will be further described in the next lines.

The study presented in chapter II presents the pattern of IMs in two Portuguese

bereaved women, corresponding to a recovered case and an improved but not recovered case. This was the second attempt to explore the pattern of IMs in CGT. In general, the results of this study were consistent with the results from the first study, showing the centrality of reflection IMs in this type of therapy and the almost absence of protest IMs. This study also showed that only the recovered case progressed to the elaboration of reconceptualization at the end of therapy. This result supports, again, the hypothesis formulated by the heuristic model of change (Gonçalves, Matos et al., 2009) proposing a distinct pattern of IMs in cases with different clinical improvements.

The study presented in chapter III, using the IMCS in a large number of complicated grief cases, documented once again the ability of this coding system to capture the narrative changes involved in CGT. It also showed the centrality of reflection IMs in this type of therapy, and a higher rate of reconceptualization production in cases with greater change when compared to cases with lower change. Another relevant result of this study was that, as therapy progressed over time, the rate of IMs production increased faster in cases with greater symptomatic improvement when compared to cases with lower clinical change, which is consistent with previous studies in different therapies (Gonçalves, Mendes, Cruz et al., 2012; Matos et al., 2009; Mendes et al., 2010). From our perspective, the higher rate of IMs production in cases with greater clinical change supports the idea that narrative changes co-occurs with therapeutic change. In CGT, specifically, it may indicate an association between the decrease of complicated grief symptomatology and the person's new ability to make sense and integrate the experience of loss in a more flexible and adaptive way (Alves et al., in press; Currier, Holland, Coleman, & Neimeyer, 2007; Keesee, Currier, & Neimeyer, 2008; Lichtenthal, Currier, Neimeyer, & Keesee, 2010; Neimeyer, Baldwin, & Gillies, 2006).

In sum, the studies presented in this dissertation support the feasibility and reliability of the IMCS in studying psychotherapeutic change in CGT, highlighting the centrality of meaning oriented forms of innovation (reflection and reconceptualization IMs) in this type of therapy (Neimeyer, 2006a; Neimeyer & Sands, 2011).

Despite the relevance of these results, further research with other relevant therapies for complicated grief is needed in order to explore the clinical implications arising from the hypothesis proposed in this dissertation.

1.2 Protonarratives in constructivist grief therapy

The hypothesis that IMs of several types start to be organized around recurrent themes throughout the therapeutic process was explored in previous studies (Bento et al., 2012; Ribeiro, Bento, Salgado, Stiles, & Gonçalves, 2011), shedding light on how protonarratives may help explain IMs' contribution to the emergence of a new and more flexible self-narrative. In general, the results of these studies suggest an association between the higher diversity of IMs and protonarratives throughout the process, and the emergence of a more flexible and inclusive self-narrative in successful therapy. They also suggest that, as treatment evolves, some protonarratives become stronger and progressively central, inaugurating an important path to the emergence of an alternative self-narrative by the end of therapy (Ribeiro, Bento et al., 2011). In unsuccessful change, in turn, the therapeutic process was characterized by a constant transition between different protonarratives, being more unstable and not progressing to the development of a central and coherent theme. The authors suggest that this permanent thematic dispersion (contrasting with the progressive narrative organization and coherence presented in successful change) may have blocked the evolution of the change process (Ribeiro, Bento et al., 2011).

The emergence and development of protonarratives in constructivist grief therapy was explored for the first time in the study of Emily and Rose (the first cases collected in the Portuguese sample), presented in chapter II. We intended to explore how two constructivist grief clients – a recovered case and an improved but not recovered case – transformed their problematic self-narratives through the elaboration of IMs and which themes or protonarratives were involved in this self-transformation process. The results of this study proposed two central themes or protonarratives associated with self-transformation in grief therapy: "Integration" and "Proactivity. "Integration" incorporated all IMs associated with clients' construction of a healthier symbolic connection with the deceased, integrating loss in a more representational way (e.g., "*I start to feel him not in his clothes or in our old house but in my memories, in every peaceful moment of my new life, because I know that my strength is now his strength too. And this new alliance frees me*"). "Integration" was the most salient theme in both cases, and its centrality is congruent with the findings from Keesee et al. (2008) and Lichtenthal, Currier et al. (2010), pointing to the capability to "make sense of" and integrate loss as a central aspect in grief adaptation.

"Proactivity", in turn, included all IMs addressing the client's search for moments of well-being and life reconstruction as alternatives to the extreme painful and immobilizing story of loss that brought them to therapy (e.g., "*Maybe it's time to think on my life in a different way, maybe I can invest in me again, and it doesn't mean that I forgot the person who died, right?*"). Some instances of this last protonarrative seem to be consistent with the "restoration orientation" process proposed by Stroebe and Schut (1999) in the "Dual Process Model", focused on persons' engagement for reorganizing life and developing new roles, new activities, or new relationships in the aftermath of loss. According to this model, the oscillation between "loss orientation" (associated with the attention to the process of loss itself, as expressed in "Integration") and "restoration orientation" (as expressed in "Proactivity") is necessary for adaptive grieving.

The relevance of "Integration" and "Proactivity" presented in chapter II motivated its further exploration in a larger sample of CGT, as presented in the study of chapter III. Thus, considering the promotion of a healthier connection with the deceased and the stimulation of new forms of life reorganization as important aspects of CGT (Alves et al., in press; Neimeyer, 2001; 2006a), we anticipated a gradual evolution of these themes across therapy, looking specifically to their progression in cases with different symptomatic improvement. In general, the results of this study corroborated the centrality of "Integration" and "Proactivity" in CGT, showing that these themes were the most salient in the entire sample (incorporating 33% and 39% of the global IMs, respectively). The remaining 28% of IMs were integrated in a category called "Others", which incorporated other narrative accounts related or not to the experience of grief. For example, "acceptance of death", referring to the client's assimilation of the notion of death as a universal experience that could be liberating to ill persons or "assertiveness", referring to the adoption of assertive positions towards abusive relationships or active resolution of other interpersonal conflicts in general. Finally, this study also showed that the rate of evolution of "Integration" and "Proactivity" was significantly higher in cases with greater symptomatic improvement. This may suggest an association between clients' ability to integrate loss (Integration) and overcome severe pain (Proactivity) with more positive grief outcomes.

In sum, this preliminary exploration of protonarratives in CGT seems to highlight the relevance of addressing clients' capacity to make sense and integrate

loss as a central aspect of grief adaptation, which is consistent with recent research in bereavement (Holland, Currier, & Neimeyer, 2006; Holland & Neimeyer, 2010; Keesee et al., 2008). Moreover, it calls our attention to the impact of clients' postmortem connection with the deceased as an important ingredient to be addressed in therapy, directing our attention to the way this investment may facilitate or inhibit the bereavement adaptation. Several studies have shown that when the survivor is unable to integrate loss in a more symbolic or representational way, the postmortem connection with the deceased may instigate higher levels of distress (Neimeyer, Baldwin, & Gillies, 2006). It is important to further explore the impact of these protonarratives in a larger number of CGT cases, followed in different therapeutic modalities.

1.3 Ambivalence in constructivist grief therapy: the re-emergence of the problematic story of loss

This dissertation also presents the study of clients' ambivalence in constructivist grief therapy (CGT), through the identification of every instance in which an IM is attenuated by a return to the problematic self-narrative (chapters II and IV).

The study of Emily and Rose presented in chapter II was the first one exploring the phenomenon of ambivalence in CGT using the Return to the Problem Coding System (Gonçalves, Ribeiro, Santos, Gonçalves, & Conde, 2009). It was our goal to analyze the relationships between innovative moments (IMs) and return to the problem markers (RPMs) in two previously unexamined complicated grief cases. That is, we wanted to explore how grief clients negotiated the processes of problematic self-narrative transformation (IMs) and problematic self-narrative maintenance (RPMs) over time, looking at the associations between these processes and their clinical improvement. The results of this study showed that both the recovered and the improved but not recovered cases presented a high percentage of RPMs (from 30% to 40%). But the most interesting result was that the evolution of IMs and RPMs was significantly correlated in both therapeutic processes (between .75 and .79, p = .001), being clearly higher when compared, for example, to a

previous study in Emotion Focused Therapy of Depression (Ribeiro, Mendes, et al., 2012), where the cross-correlation between IMs and RPMs was .39 (p = < .001). These results led us to consider that the response of ambivalence may have a particular function in this type of therapy, associated with a strategy of self-protection (Engle & Holiman, 2002) from the anxiety of investing in self-change as a disconnection from the "painful bond" with the lost person (that the person may not be willing or prepared to reformulate).

In order to further explore this hypothesis, the phenomenon of ambivalence was then studied in a sample containing six CGT cases, which corresponds to the study presented in chapter IV. In a different manner from what was found in study 2, the study with the larger sample showed a high level of heterogeneity in the way the six cases managed oscillations between change and the re-emergence of the problematic self-narrative over the course of therapy. In fact, the cases of Emily and Rose (whose results were also integrated in the larger sample) remained as the cases with higher associations between IMs and RPMs. We consider that more studies with larger samples are needed in order to further explore the role of ambivalence in grief therapy. Thus far, these results highlight the importance of considering clients' different change processes (associated with their unique resources, vulnerabilities and expectations) in order to understand their investment in change and ambivalence, knowing that different persons may feel more or less confortable in living loss and grief in a different way. Thus, as we have speculated in chapter II, the stronger maintenance of ambivalence may reflect the way certain clients choose to deliberately attenuate their investment in self-change in order to preserve the previous story of loss and the previous connection with the deceased ("*If I'm suffering like this, it means that I keep caring about the person that I lost, we keep connected through this pai*n"). It may be extremely difficult for some persons to try a different and less painful connection with the lost person (Rando, 2012). As expressed by the Brazilian singer Marisa Monte in one of her songs about loss "*If I don't have my love, I have my pain*".

These hypotheses may have relevant implications for grief therapy. First of all, it is important to note that the therapist must respect the way different clients live their different emotions during the experience of grief (e.g. pain, guilt, joy or relief) and reassure them about the relevance of these emotions as legitimate ingredients of their unique experience of loss. In this line of reasoning, it is important to note that

grief adaptation does not necessarily requires an "emancipation" from pain but its reformulation in a less severe and impairing form. When the client does not feel comfortable in reformulating his or her intense pain, it is important to integrate this type of resistance to change in therapy, exploring the meanings associated with his or her intense suffering and the expectations and fears associated with the change process. In a recent chapter of the book *Techniques of Grief Therapy, Creative Practices for Counseling the Bereaved* (edited by Robert Neimeyer), Rando (2012) suggests an intervention called "Is it Okay for You to Be Okay?" which is consistent with this line of reasoning. According to this author, "healthy mourning after loss, like healthy living in its wake, both mandate that a mourner implicitly or explicitly make the decision that it is all right to be unimpaired and experience well-being" (p. 149). Thus, it is important to identify and explore clients' beliefs about "pain and well-being" in the wake of loss and propose therapeutic activities that are aware of potential "self-imposed" restrictions (Rando, 2012).

I believe that further information about this type of resistance to change in grief therapy could also be gathered from the exploration of cultural and social expectations associated with the "normal versus abnormal" grieving. As pointed out by Neimeyer, "grief is as much a social as individual process, and more attention is needed into how social groups can support or impede the adaptation of their members" (2006b, p. 184). For instance, it may be difficult to live and share a less painful experience of grief in a cultural context that is still modulated by traditional theories of grief proposing pain and sorrow as the "expected" reactions to a significant loss while emotions such as pleasure or happiness may be seen as abnormal or unexpected ones (Hagman, 2001), perceived as a "lack of commitment" with the experience of grief itself. There is a lack of research exploring the cultural and social aspects of grief and loss in Portugal. Future studies should address these questions so that a larger consideration of the cultural aspects of the story of loss brought to therapy can be considered and integrated in the intervention.

Studies 2 and 4 also showed a different RPMs evolution by the end of therapy between cases with different symptomatic improvement. While the frequency of RPMs decreased progressively by the end of therapy in cases with higher symptomatic improvement (which includes the recovered case from study 2), it remained high and irregular in cases with lower symptomatic improvement (which includes the improved but not recovered case from study 2). This difference between

cases – centered not in the emergence but in the progression of RPMs – is consistent with the results from previous studies, showing a progressive decreasing of RPMs in good outcome cases, while the opposite movement occurs in poor outcome cases (Gonçalves, Ribeiro, Stiles et al., 2011; Ribeiro, Cruz, et al., 2012; Ribeiro, Mendes et al., 2012). Thus, as suggested by Ribeiro (2012), it is not the emergence of RPMs but their persistence until the advanced stages of therapy that significantly affects the therapeutic outcome.

The exploration of the different narrative evolutions among cases with different clinical progressions (chapter IV) also showed that sessions with higher diversity of IMs (4 or more types) presented significantly less RPMs than sessions with low IM diversity (1 to 3 types). Furthermore, sessions in which the higher diversity of IMs was associated with the emergence of reconceptualization presented even lower percentages of RPMs, suggesting that the emergence of reconceptualization in sessions in which other types of IMs also emerge may represent a privileged scenario to the development of a more stable change process, characterized by lower levels of ambivalence (Cunha, Gonçalves, Valsiner, Mendes, & Ribeiro, 2012; Alves et al., 2013). The emergence of reconceptualization was also a distinguishing process between the therapeutic evolutions of Emily and Rose (chapter II): while Emily (the recovered case) achieved a meta-understanding of the processes that allowed her self-transformation (through reconceptualization) and started to reformulate her problematic story of loss under a more symbolic connection with the deceased ("integration"), Rose (the improved but not recovered case) did not achieve this reintegration and self-reformulation under a meta-reflexive position (absence of reconceptualization). This result corroborates, again, the central role of reconceptualization in the resolution of ambivalence (Cunha, Gonçalves, & Valsiner, 2011; Cunha et al., 2012; Gonçalves, Matos et al., 2009), associated with clients' ability to deal with the anxiety prompted by the change process and to establish a meaning bridge between the old and the new self-narratives (reconceptualization), so that the novelties may stop being considered as a threat to self-stability and start to be integrated in a more flexible self-narrative (Gonçalves & Ribeiro, 2012; Gonçalves, Ribeiro, Stiles, et al., 2011).

2 FINAL REMARKS

The studies integrated in this dissertation have different limitations that I acknowledged in the corresponding chapters. In general, the small sample size from which the conclusions have been drawn limits its generalization to other CGT clients.

Another major limitation of this study relies on the overlap of my work as therapist and coder of the therapeutic processes of the Portuguese sample. This limitation is associated to the fact that all studies presented in this dissertation were developed under my PhD program, which proposed an exploratory attempt to study narrative change in constructivist grief therapy. Thus, it required a training process in this specific therapeutic modality in order to be able to collect this sample, followed by an intensive analysis of all sessions regarding the emergence of IMs, protonarratives and RPMs. We consider that this limitation may bring to light some methodological problems, as I was not unaware of clients' clinical outcomes and specific therapeutic progressions, which influenced the way I coded their sessions. But on the other hand, I also consider that my intensive knowledge of all the specificities of each therapeutic case also enriched the coding process with the other judges (all of them unaware of cases' clinical outcomes).

Despite these main limitations, I believe that the conclusions presented throughout this dissertation brought relevant information for clinical and research work in complicated grief. More specifically, the analysis of all therapeutic sessions in terms of IMs and protonarratives may have provided a fine-grained portrayal of the narrative processes involved in grief therapy and how these narrative constructions impact complicated grief recovery. The RPMs analysis may also have provided relevant information about the way complicated grief clients with different symptomatic improvements address ambivalence in psychotherapy, and how this process may influence their timing of change and clinical recoveries. By being aware of these processes and the way different clients may negotiate them in therapy, the therapist may be better prepared to propose different therapeutic interventions that are congruent with client priorities and expectations (Alves et al., in press; Rando, 2012).

I would like to end this conclusion by proposing a final future direction. Although the central goal of this dissertation is to shed light on clients' efforts to

reorganize their meaning systems while joining the therapeutic dialogue, I believe that future research on the impact of the therapist' interventions in the way change and ambivalence are negotiated over time will be particularly relevant. E. Ribeiro, A. P. Ribeiro, Gonçalves, Horvath and Stiles (2012) have recently proposed a methodological tool called *Therapeutic Collaboration Coding System* (TCCS) to analyze the impact of the therapist-client interaction in the way change progresses over time. Regarding clients' ambivalence, for instance, A.P. Ribeiro, E. Ribeiro, Loura, Stiles, Sousa, Horvath and Gonçalves (2012) suggest that the emergence of RPMs tends to appear when the therapist proposes more challenging interventions, stimulating a more intense reaction of self-protection against uncertainty or unfamiliarity. Thus, it would be important to explore the implications of specific interventions in the way grief clients manage their change processes throughout therapy, analyzing how therapists from different therapeutic frameworks may contribute to the emergence and expansion of IMs and RPMs in therapy (Ribeiro, 2012).

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